No. (1)

Supreme Court, U.S.
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In The

Supreme Court of the United States

JAMES C. LOWE,

Petitioner,

v.

WAL-MART STORES, INC. ASSOCIATES HEALTH AND WELFARE PLAN, and WAL-MART STORES, INC., as "De facto Plan Administrator, and, DAVID D. GLASS, JOHN B. MENZER, PAUL R. CARTER, JOSEPH S. HARDIN JR., as Plan Trustees, and THE ADMINISTRATIVE COMMITTEE, as Plan Administrator,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. When "ERISA" Group Health Plan Documents are ambiguous and Conflict of Interest is established, which Standard of Review is proper, in light of *FIRESTONE v. BRUCH*, 489 U.S. 101 (1989).

2. Whether Georgia State Law is preserved under "ERISA" to such a degree as to control "Assignment of the Right of Recovery" to the Health Care Provider.

3. Whether Affirmation of Summary Judgment by 11th Cir. Denies Due Process, when 7th Cir. requires Bench Trial on Issue of Subrogation, pursuant to *WAL-MART v. WELLS*, 24 E.B.C. 1673 (7th Cir. 2000).

4. Whether "ERISA" Judicial Reviews should be subject to exclusive resolution under "The Federal Arbitration Act," pursuant to *GILMER v. INT./JOHNSON LANE CORP.*, 500 US 20.

5. Whether Plan Participants or Beneficiaries are required to execute an Agreement that creates an "Illegal Contract."

6. Whether Plan Participants or Beneficiaries are entitled to application of "The Make Whole Doctrine."

7. Whether Claims Preclusion, Collateral Estoppel and Res Judicata prevent Assertion of Defenses within a Federal Action, where adjudication on "Issue of Liability" has been previously decided and lawfully established within the Georgia State Court in light of the BURFORD DOCTRINE. *BURFORD v. SUN OIL*, 319 U.S. 315 (1943).

8. Whether "ERISA" Plan Participants and Beneficiaries are DENIED DUE PROCESS, guaranteed by U.S. and

QUESTIONS PRESENTED – Continued

Georgia Constitutions, and do "ERISA" Plan Participants and Beneficiaries face UNCONSCIONABLE TERMS AND PROVISIONS with "NO ABILITY TO BARGAIN."

9. Whether Professional Misconduct, within State Court should be tolerated so that defense of client may be accomplished by Any Means Available Lawful or Otherwise.

10. Whether The ERISA ACT is UNCONSTITUTIONAL, regarding Single Employer Health Care Benefit Plans.

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PETITION FOR WRIT OF CERTIORARI

Petitioner respectfully prays that a writ of certiorari issue to review the judgment below.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Eleventh Circuit (App.1-11) is unreported. The opinion of the District Court (App.12-25) is unreported. Final Judgment of State Court of Fulton County (App.37-39) is unreported. Denial of petition for rehearing (App.40-41) is unreported.

JURISDICTION

The District Court had Federal Question Jurisdiction over Plaintiff's claims pursuant to 28 *U.S.C.A.* 1331. The Eleventh Circuit Court of Appeals had Jurisdiction to review the final judgment of the District Court pursuant to 28 *U.S.C.A.* 1291.

The Eleventh Circuit Court of Appeals' opinion was entered on January 9, 2004. The court denied petition for rehearing en banc on April 9, 2004. 28 *U.S.C.* 2403(a) may apply.

Petitioner LOWE is unaware of any certification pursuant to 28 *U.S.C.* 2403(a), to the Attorney General, by the Eleventh Circuit Court of Appeals, with regard to the fact that the Constitutionality of an Act of Congress has been brought into question, as the Eleventh Circuit failed to rule on the issue. This Honorable Court has Jurisdiction under 28 *U.S.C.A.* 1254(1).

This proceeding draws into question the issue of proper procedural "*Due Process of Law*" to be afforded in ERISA actions for recovery of Health Care Benefits, and questions the Constitutionality of ERISA.

CONSTITUTIONAL PROVISIONS, STATUTES AND ORDINANCES

1. THE CONSTITUTION OF THE UNITED STATES

Art. I Sec. 9 (Cl. 3 and 10).

Provide in pertinent part:

(Cl.3) "No Bill of Attainder or Ex Post Facto Law shall be passed."

(Cl. 10) "No State shall . . . pass any Bill of Attainder, Ex Post Facto Law, or Law Impairing the Obligation of Contracts . . . "

Art. III Sec. 2 Par. [2] Provides in pertinent part:

" . . . In all the other Cases before mentioned, the Supreme Court shall have appellate Jurisdiction, both as to law and fact, . . . "

2. **The Fifth Amendment to the Constitution** provides in pertinent part: "nor shall any person . . . be deprived of life, liberty, or property, without due process of law."

3. **The Tenth Amendment to the Constitution** provides: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States are reserved to the States respectively, or to the people."

4. **The Fourteenth Amendment, Sec. 1 to the Constitution** provides in pertinent part: "No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States, nor shall any State deprive any person of life, liberty or property without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

5. **The Federal Arbitration Act ("FAA")**, 9 *U.S.C.A.* 1 *et seq.* "Provides for resolution of disputes and claims subject to mediation and arbitration." ERISA actions are subject to the "FAA."

6. **The McCarran Ferguson Act**, 15 *U.S.C.A.* 1011 *et seq.* provides in pertinent part: "That the ability to regulate Insurance . . . will be reserved to the several States."

7. **The Employee Retirement Income Security Act (ERISA)**, 29 *U.S.C.A.* 1001 *et seq.* is a comprehensive Act that deals with pension plans and group health benefit plans. The stated purpose of ERISA "is to ensure that each plan participant and beneficiary receive all of the benefits due to said individual."

8. **Labor Regulations Sec. 2560.503-1(b)(1)(iii)** provides in pertinent part: "Does not contain any provision and is not administered in a way, which unduly inhibits processing of Plan Claims."

9. **Federal Rules of Appellant Procedure**, Rule 36 I.O.P. (2) and F.R.A.P. Rule 36 I.O.P., 11th Cir.R. 36-2 establish the Rule of "Binding Precedent" and "Persuasive Precedent." Mandates issued by the Court are Binding or Persuasive respectively.

10. **Federal Rules of Civil Procedures**, Rule 12(a)(1)(A), Rule 16(b), Rule 16(e), and Rule 26(a)(1), (e)1, as further shown in 151 FRD 147 and Rule 37

establish mandated Rules to be observed within District Courts.

11. CONSTITUTION OF GEORGIA

Art. I Sec. I Par. I	"No person shall be deprived of life, liberty or property except by due process of law."
Art. I Sec. I Par. X	Provides in pertinent part: "No bill of attainder, ex post facto law, retroactive law, or laws impairing the obligation of contract or making irrevocable grant of special privileges or immunities shall be passed."

12. GEORGIA ARBITRATION CODE, *O.C.G.A.* 9-9-1 *et seq.* provides for "Alternative Dispute Resolution" and mirrors the Fed. Arbitration Act, as further set out in "No. 5" above.

13. *O.C.G.A.* 1-3-5; 1-3-10; 9-11-17(a); 9-11-56(c); 9-12-16; 9-12-40; 10-7-4; and 13-8-2 are Georgia Codes of General Application, therefore would enjoy "*Preemption Exemption*" under ERISA.

14. *O.C.G.A.* 9-11-17 is a Georgia State Statutory Code that allows absolute assignment of a given right under Georgia Law.

The Supreme Court of Georgia has interpreted this Statute within: *Allianz Life v. Riedl*, 444 S.E.2d 736 (Ga. 1994), resulting in the decision that "*Assignment*" under Georgia Law is "*Absolute*" and said ruling by the highest Court in this State is binding on the Eleventh Circuit Court of Appeals. This Statute "*Regulates Insurance*" and therefore would enjoy "*Preemption Exemption*" under ERISA.

15. ***O.C.G.A.* 10-7-4** is a Georgia State Statutory Code that establishes the relationship of *"Suretyship."* This Code is used in insurance contracts and therefore would enjoy *"Preemption Exemption"* under ERISA.

16. ***O.C.G.A.* 33-24-56.1** is a Georgia State Statutory Code that establishes *"The MAKE WHOLE DOCTRINE."*

17. ***O.C.G.A.* 44-12-24** is a Georgia State Statutory Code that forbids *"Assignment of the Right of Action"* against a third-party tort-feasor.

    The Georgia Supreme Court has interpreted this Statute within *Wrightsman v. Hard. Deal. Mut. Insurance Co.*, 147 S.E.2d 860 (Ga. 1966), resulting in the decision that "Assignment of the Right of Action against a Third-Party Tort-feasor is Forbidden" and said ruling by the highest Court in this State is binding on the Eleventh Circuit Court.

STATEMENT OF THE CASE

(i) Course of the Proceedings and Disposition Below

On June 9, 1998, the Plaintiff, James C. Lowe, filed his five count complaint in the Eleventh Judicial Circuit in Atlanta-Fulton County, Georgia (R1-1), which alleged violation of the Employee Retirement Income Security Act, 29 *U.S.C.A.* 1001 *et seq.* ("ERISA") for failure to process medical insurance claims, invalid ERISA Plan Documents, failure to produce documents, breach of fiduciary duty and requested other equitable relief. On July 1, 1998 "All Defendants" filed their answer to Plaintiff's complaint.

On March 2, 1999, the Plaintiff, James C. Lowe, filed his four count amended complaint (R2-37) pursuant to Court Order (R2-32) in the Eleventh Judicial Circuit in Atlanta-Fulton County, Georgia. All Defendants filed their "untimely answer" to Plaintiff's amended complaint (R2-39).

On March 17, 1999, Pretrial Conference (R2-38) was commenced to determine whether this Federal Action should be stayed pending resolution of the two related cases in Fulton County State Court. Order for stay was issued on May 24, 1999 (R2-46). Judge Evans ruled that State Law was controlling and disposition in State Court Actions would be dispositive with regard to Federal Action. (T4 p. 27) District Court's ruling triggers State Law control of all substantive issued. *FMC Corp. v. Holiday*, 498 U.S. 52 (1990).

On June 24, 2002, Summary Judgment (R3-55) was granted to Defendants based upon a *"Void Judgment"* within Superior Court of Fulton County, lack of jurisdiction *Holbrook* GA and improper retrospective application of *Cagle v. Bruner* (11th Cir. 1997). Subrogation rights are fixed at time of occurrence. *Hayes* and *Anthony* SUPREME COURT OF GEORGIA.

Plaintiff Lowe moved the District Court to alter or amend judgment on July 5, 2002. On March 4, 2003, District Court denied Plaintiff's Motion. On March 17, 2003, Plaintiff Lowe moved the District Court for relief from judgment. On May 12, 2003, District Court denied Plaintiff's Motion. On May 12, 2003, District Court granted Plaintiff's Motion for enlargement of time to file Notice of Appeal. Notice of Appeal was filed with the District Court on May 20, 2003.

On July 1, 2003, Appeal was taken from grant of summary judgment, by the District Court to the Eleventh Judicial Circuit Court of Appeals. On January 9, 2004, the Eleventh Judicial Circuit Court of Appeals denied appeal and Petitioner Lowe moved the Court for EN BANC Review. Petition for EN BANC Review was denied on April 9, 2004. (App.40-41)

(ii) Statement of the Facts

Plaintiff James C. Lowe ("Lowe") was involved in an automobile accident in August 1994. Subsequently, Lowe obtained medical services for related injuries from numerous medical providers, including State Court Plaintiff, Columbia West Paces Ferry Medical Center ("West Paces") and companion case Plaintiff, Center Neurology Inc. (R3-51). Exhibits "N" & "N1".

Lowe is entitled to "Group Health Plan Benefits," as an "*Eligible Spouse*" 29 *U.S.C.A.* 1002(8), 1167(3)(A)(i) under Defendant WAL-MART STORES, INC. ASSOCIATES HEALTH AND WELFARE PLAN ("HEALTH PLAN"). Lowe was enrolled in HEALTH PLAN by his wife Belinda Lowe. The HEALTH PLAN "*Trust*" is administered by Co-Defendant, WAL-MART STORES, INC. herein ("WAL-MART"). (R3-65 p.5) and Exhibit "C."

Lowe filed claims for benefits from HEALTH PLAN to cover medical expenses incurred subsequent to the automobile accident. HEALTH PLAN "*Initially Granted*" Lowe's benefits triggering "*Make Whole Doctrine.*" *Gries* 11th Cir., paying several thousand dollars in medical claims submitted by Lowe. (R3-51) and Exhibits "F" through "M". Eleventh Circuit Opinion erroneous, Lowe's benefits were "*Initially Granted.*"

Shortly thereafter, HEALTH PLAN submitted a proposed "*Subrogation Agreement*" to Lowe. Said Subrogation Agreement was imposed for an improper purpose. The "Subrogation Agreement" intended to acquire "*The Right of Action*" for WAL-MART HEALTH PLAN against the Third-Party Tort-Feasor. (R3-65) and Exhibits "B," "B1" and "B2". Circuit Opinion clearly erroneous. Contracts Terms are not preempted by ERISA. *Metropolitan Life v. Massachusetts*, 471 U.S. 724 (1985).

(iii) Statement of the Issues and Denial of Due Process

The standard of review for grant of summary judgment, as affirmed by the Eleventh Circuit Court of Appeals is "*de novo.*" Legal Conclusions reviewed de novo, *Pullman-Standard v. Swint*, 456 U.S. 273 (1982), Material Facts reviewed de novo, *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242 (1986). U.S. Constitution, Art. III Sec. 2 Par. 2.

Summary judgment is proper only when the pleadings, depositions and affidavits show that there is not a genuine issue of material fact and the moving party is entitled to judgment as a matter of law. *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986), quoting Rule 56(c) of the Federal Rules of Civil Procedure. The Eleventh Circuit Court must view the evidence in the light most favorable to non-moving party. *Welch v. Celotex Corp.*, 951 F.2d 1235, 1237 (11th Cir. 1992). The Eleventh Circuit Court reviews District Court's findings of fact for ERISA Benefit Plan under the clearly erroneous standard. *Guy v. Southeastern Iron Workers*, 877 F.2d 37 (11th Cir. 1989). The Eleventh Circuit Court had jurisdiction pursuant to 28 *U.S.C.A.* 1291.

Plaintiff-Petitioner Lowe has set out nine unresolved issues on "page 30" of this Petition. Resolution and application of relevant law will result in a different ruling. The United States Supreme Court would use plenary review and observe *"DENIAL OF DUE PROCESS,"* within the District Court.

SUMMARY OF ARGUMENT

Pursuant to ERISA and applicable surviving Georgia State Law, Petitioner James C. Lowe is entitled to group health care benefits from the WAL-MART STORES, INC. ASSOCIATES HEALTH AND WELFARE PLAN.

1. WAL-MART STORES, INC. established the WAL-MART HEALTH PLAN and is *"Settler"* of the WAL-MART STORES, INC. ASSOCIATES HEALTH AND WELFARE PLAN TRUST, and is the *"De Facto Plan Administrator."* (R3-65), App.Br.P.3.

2. The WAL-MART "ERISA PLAN DOCUMENTS" confer "Mutually Exclusive Rights" to the Plan Administrator. The right of *"Subrogation"* and *"Reduction and Reimbursement"* cannot co-exist within the same ERISA Plan agreement and are exclusive one to the other. (R3-57, Ex. "B"). *Weber v. Sentry, Ins.*, 442 N.W.2d 164 (1989). (R3-65), App.Br.PP.4 & 13. Language must be unambiguous. *Sayers v. Rochester, Tel. Corp.*, 7 F.3d 1091 (1993); *Firestone v. Bruch*, 489 U.S. 101 (1989); *Ingersoll-Rand v. McClendon*, 498 U.S. 133 (1990); *Godfrey v. Bell South Tel.*, 89 F.3d 755 (11th Cir. 1996); *Bituminous v. Advanced*, 73 F.3d 335 (1996); *Hunt v. Hawthorn*, 119 F.3d 888 (11th Cir. 1997); *A. L. Williams v. Steck*, 960 F.2d 942 (11th Cir. 1992); CONTRA PROFERENTUM

Kunin v. Benefit Trust Life, 910 F.2d 534 (9th Cir. 1995).

3. The WAL-MART "ERISA PLAN DOCUMENTS" attempt to secure through "*Assignment*" "*The Right of Action*" against any at fault Third-Party Tort-Feasor. 1993 WAL-MART Plan Documents. (R3-59) (R3-65), App.Br.PP.13 & 14. Assignment of the right of action against an at fault tort-feasor is forbidden under Georgia State Law:

   O.C.G.A. 44-12-24, as interpreted by the Supreme Court of Georgia: *Wrightsman v. Hardware Dealers Mutual Ins.*, 147 S.E.2d 860 (Ga. 1966). (R3-59), App.Br.PP.13 & 14.

4. Petitioner Lowe was enrolled in the WAL-MART HEALTH PLAN on or around January 1, 1993, by his wife Belinda, a WAL-MART employee. Petitioner Lowe has not signed any documents regarding his coverage under the WAL-MART GROUP HEALTH PLAN. "Pleadings and Responses Supra." Lowe is a "*Non-Signatory Beneficiary*." App.Br.P.15.

5. Petitioner Lowe's wife and WAL-MART agreed that the WAL-MART HEALTH PLAN would pay future medial expenses incurred by Lowe from January 1, 1993. Said agreement creates an "*IRREVOCABLE TRUST*" in favor of Plaintiff-Petitioner Lowe. "Lowe's benefits granted." App.Br.P.3. Petitioner Lowe is "*BENEFICIARY OF AN IRREVOCABLE TRUST*" and therefore a "*TRUST LAW USUFRUCTUARY*" whose benefits cannot be lawfully denied. *PROMISSORY ESTOPPEL*. App.Br.P.15.

6. The District Court did not rule on issue of *UNCONSCIONABILITY OF CONTRACT*. (R3-55 p.5), (R3-65 p.5), App.Rep.Br.P.5.

7. The District Court applied improper "*Standard of Review*" pursuant to *Firestone v. Bruch*, 489 U.S. 101 (1989). App.Br.P.1.

8. The District Court allowed an "Untimely Answer" by Defendants in violation of *F.R.Civ.P.* Rule 12(a)(1)(A).

9. The District Court modified the Scheduling Order in violation of *F.R.Civ.P.* 16(b). (R1-26).

10. The District Court did not issue a Pretrial Order in violation of *F.R.Civ.P.* Rule 16(e). App.Br.PP.11 & 12. Surviving Georgia State Statutory Law was not applied by the District Court. (R3-65), App.Br.P.11.

11. The District Court failed to uphold *F.R.Civ.P.* Rule 26(a) regarding "*Mandatory Disclosures*" by Defendants. *See* 151 FRD 147 (1993). App.Br.PP.11 & 16.

12. The District Court failed to enforce provisions within *F.R.Civ.P.* Rule 37 "*Discovery Sanctions*" regarding Defendant's failure to cooperate in proper discovery procedures. App.Br.PP.11-12 & 16.

13. The District Court failed to establish Claims Preclusion, Res Judicata and Collateral Estoppel based upon State Court Arbitration Award and Judgment. *Moate v. Moate*, 456 S.E.2d 502 (Ga. 1995). (R3-64) App.Br.PP.18-20.

14. Despite "*overwhelming evidence*" to the contrary, the Eleventh Circuit Court of Appeals found no reversible error. Eleventh Circuit Opinion. (App.1-11)

The Eleventh Circuit has entered a judgment that conflicts with the Seventh Circuit's "*Bench Trial Rule*" when issues of *Subrogation, Reduction & Reimbursement* are at issue. *WAL-MART v. Wells*, 24 EBC 1673 (7th Cir. 2000). Judgment conflicts with Supreme Court of Georgia

on issue of "*Assignment against Third-Party Tort-feasors.*" Judgment has sanctioned such a departure from the accepted and usual course of judicial proceedings within the District Court as to question the existence of "*THE RULE OF LAW*" within this action, to such a degree as to call for exercise of this Court's supervisory power. *Supreme Court Rule* 10(a)(b)(c).

ARGUMENT AND CITATION OF AUTHORITY

(i) Summary Judgment entered for Defendants was Unwarranted based on the Totality of the Circumstances and Facts presented in this Action

The district court's entry of summary judgment for the defendants within this action epitomizes the abysmal state of affairs within the Health Care Industry and illuminates the plight of Plan Participants and Beneficiaries, who are facing "*inhospitable terms and unconscionable provisions*" of an "ERISA" Group Health Care Benefit Plan. UNCONSCIONABILITY: *Williams v. Walker-Thomas*, 350 F.2d 445 (DC Cir. 1965)

Plan Participants and Beneficiaries covered under a "*Single Employer Benefit Plan*" where the Plan is drafted by the Plan Sponsor of his Agents and the Participants do not have an "*Employee Association*" to secure through collective bargaining a "Proper Health Care Benefit Plan" are subject to implausible, unconscionable terms that lack fundamental fairness and favor the Plan over the rights of Participants and Beneficiaries in contravention of ERISA Plan Goals. ERISA, 28 *U.S.C.A.* 1001b(c)(3), 1103(c)(1).

The Employee Retirement Income Security Act, 29 *U.S.C.A.* 1001 *et seq.* (1974) ("ERISA") was originally

conceived as a bulwark against "Pension Benefit Trust Raiders" such as the infamous 1960's Teamsters Union scandal. The rampant "Theft and Misappropriation of Pension Funds" left many thousands of individuals without means to provide for their families, which resulted in public outcry for legal remedy.

ERISA does a good job of supervising the Plans Retirement Funds through The Pension Benefit Guarantee Corp., but is woefully inadequate with regard to Health Care Benefit Plans. Provisions within ERISA unjustifiably favor the "Plan Sponsor" (Employer) over the best interests of "Participants and Beneficiaries" (Employees and Family). Grant of Sum. Jud. conflicts with Seventh Circuit. *WAL-MART v. Wells* (2000).

(ii) WAL-MART STORES, INC., is Sponsor of ERISA Plan and Settler of ERISA Health and Welfare Plan Trust

WAL-MART STORES, INC. ("WAL-MART") is "*SPONSOR*" of THE WAL-MART STORES, INC. ASSOCIATES HEALTH AND WELFARE PLAN. ("HEALTH PLAN"). WAL-MART is "*SETTLER*" of THE WAL-MART STORES, INC. ASSOCIATES HEALTH AND WELFARE PLAN TRUST ("HEALTH PLAN TRUST"). WAL-MART is "*PLAN ADMINISTRATOR*" of HEALTH PLAN by Statute, when "autonomous Administrator" is not designated, 29 *U.S.C.A.* 1002(16)(A)(ii). The District Court failed to establish, or even acknowledge this Statutory Provision, which stands as an "Incontrovertible Fact," and has resulted in application of an erroneous "Standard of Review." Conflicted Plan Administrator subject to "*Heightened Arbitrary and Capricious Standard of Review.*" *Firestone v. Bruch*, 489 U.S. 101 (1989).

Legal Conclusions reviewed *de novo Pullman-Standard v. Swint*, 456 U.S. 273 (1982), Material Facts reviewed *de novo Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242 (1986).

When "*ERISA PLAN DOCUMENTS*" grant the right to *The Plan Administrator* to construe "*THE TERMS OF THE PLAN*," "*The Plan Administrator*," *WAL-MART*, becomes a "*FIDUCIARY*" of *THE WAL-MART HEALTH PLAN TRUST*. 28 *U.S.C.A.* 1002(21)(A) and is bound by Trust Law Principles to *Administer HEALTH PLAN* "In the Best Interest of Plan Participants and Plan Beneficiaries." ERISA, 29 *U.S.C.A.* 1001b(c)(3). Failure to administer the HEALTH PLAN TRUST as set forth above is "*Breach of Fiduciary Duty*." ERISA, Sec. 401-406. Determinations for Health Care Benefits, that further the interests of the Plan Administrator, and Defeat the best interests of the Plan Participants and Beneficiaries are not permitted. Benefit Denial is "*Ulterior Profit Motive*" for SPONSOR-PLAN ADMINISTRATOR-FIDUCIARY-SETTLER of the HEALTH PLAN TRUST, based upon the fact that ERISA BENEFIT TRUSTS are considered to be "*GRATUITOUS TRUSTS*" and the "Corpus or Res of the Trust" reverts back to *SETTLER*, upon dissolution of TRUST, Restatement of Trusts 2d 430. Therefore, "Unclaimed Benefits" become "*Unjust Enrichment*" for the WAL-MART PLAN.

The foregoing clearly establishes a prima facie case of "*Perpetual Conflict of Interest*" within the SPONSOR-PLAN ADMINISTRATOR-FIDUCIARY-SETTLER. The "*For Profit Interests*" of WAL-MART are in a "*Perpetual State of Conflict*" with the "*Fiduciary Duty*" of the Plan Administrator. This "*Conflict*" is clearly demonstrated when "Valid Claims for Benefits" are frivolously denied. Restatement of Trusts 2d 187.

When the foregoing situation is established, it then requires the Conflicted Administrator to be subjected to a "Heightened Arbitrary and capricious Standard of Review." *Firestone v. Bruch*, 489 U.S. 101 (1989). Restatement of Trusts 2d 187(d) 1959. The District Court used "Arbitrary and Capricious Standard of Review" in error. The Eleventh Circuit Panel "Affirmed" in error.

(iii) ERISA Plan Fiduciaries Bound by Trust Law

As further set forth within (ii) above, the ERISA Plan Administrator becomes a *"TRUST FIDUCIARY"* and is therefore subject to application of TRUST LAW. The U.S. Supreme Court has established that the Language of Trust abounds within ERISA. *Firestone* (1989). If "Plan Administrator-Fiduciary" is regulated by TRUST LAW, then TRUST LAW must be equally applied to Plan Participants and Plan Beneficiaries, for not to do so would result in *"Denial of Equal Protection under the Law."* U.S. CONST. Because "TRUST LAW PRINCIPLES" are applied to an ERISA PLAN ADMINISTRATOR-FIDUCIARY, they must also be applied equally to ERISA Plan Participants and Beneficiaries. Failure to apply TRUST LAW to all parties results in "Denial of Equal Protection under the Law." All Parties must be treated equally under the same applicable laws. United States Constitution, Amendments 5 and 14 Sec. 1. Constitution of Georgia, Art. I Sec. I Par. I.

(iv) ERISA Plan Beneficiaries are Beneficiaries of an Irrevocable Trust and become a Usufructuary

When two parties agree to assume the responsibility to pay the debts of another, an IRREVOCABLE TRUST is created by operation of law.

"WAL-MART HEALTH PLAN" and Lowe's wife agreed to enroll Lowe in the WAL-MART HEALTH PLAN. Lowe was enrolled and coverage began for Lowe on January 1, 1993. Lowe did not execute any documents or make any agreements with WAL-MART regarding his coverage, under the WAL-MART GROUP HEALTH BENEFIT PLAN. Plan Participant is "*Signatory*" on agreement and Beneficiary is "*Non-Signatory*." No agreement exists with *Non-Signatory*.

Based on the foregoing under applicable TRUST LAW, Lowe is a Beneficiary of an IRREVOCABLE TRUST, and therefore, Lowe is a "*TRUST LAW USUFRUCTUARY*." As a *Lawful Usufructuary*, Lowe's benefits cannot be denied. Attempt to deny Lowe's lawful benefits becomes "*Breach of Fiduciary Duty*" of PLAN ADMINISTRATOR-FIDUCIARY under ERISA. ERISA Sec. 401-406.

(v) ERISA Plan Beneficiaries not bound by Plan Covenants

As further set forth within No. (iv) above, under proper application of TRUST LAW, Lowe is a "*Lawful Usufructuary*" whose health care benefits cannot be denied and who has no agreement with the WAL-MART GROUP HEALTH BENEFIT PLAN. Accordingly, Lowe, a "*Non-Signatory Beneficiary-Usufructuary*," is not subject to Plan provisions such as "*Subrogation and Reduction and Reimbursement*." WAL-MART HEALTH PLAN has not produced any documents that demonstrate that Lowe has made any agreement with the WAL-MART HEALTH PLAN regarding such provisions. Pleadings and Responses. Supra.

The District Court's assertion that Lowe has not caused explanation of his refusal to execute a Subrogation and Reduction Agreement with WAL-MART HEALTH PLAN is clearly erroneous. Petitioner Lowe is not required to execute any document as there is no agreement with WAL-MART HEALTH PLAN with regard to any duty imposed on Lowe. Petitioner Lowe has explained numerous times to the District Court his reasons for refusal to execute such a document on the grounds that such an agreement would create an "*Illegal Contract*," *O.C.G.A.* 13-8-2, based on the fact that such contract would create an "*Impermeable Assignment of The Right of Action*" against a Third-Party Tort-Feasor, which is strictly forbidden under Georgia State Law, *O.C.G.A.* 44-12-24. WAL-MART HEALTH PLAN WRAP Document Section 5.4, effective from 1993 through 1995 requires assignment of the Right of Action, with specific intent to bring an action against the at fault Third-Party Tort-Feasor. Such action is forbidden under Georgia Law. *Wrightsman v. Hard. Deal Mut. Ins.*, 147 S.E.2d 860 (Ga. 1966). "Supreme Court of Georgia interpreting Georgia State Code."

(vi) Claims Preclusion, Collateral Estoppel & Res Judicata

Plaintiff-Petitioner Lowe has demonstrated to the District and Eleventh Circuit Courts through "*Incontrovertible Evidence*" which is "*Clear Convincing and Unequivocal*" the fact that a lawful "*Arbitration Award and Judgment*" exists against Defendant-Appellee WAL-MART STORES, INC. d/b/a WAL-MART STORES, INC. ASSOCIATES HEALTH AND WELFARE PLAN.

The aforementioned judgment was submitted to the District Court in 2003 as noted within Appellant Lowe's

Brief: Pages 19 & 22; additionally, a "*Certified Copy*" of the lawful judgment of the State Court was filed with Appellee WAL-MART's Reply to Appellant Lowe's Response to Supplement the Record. Defendant-Appellee WAL-MART's Response, Exhibit "A" *See: "BURFORD DOCTRINE"* (R3-57). Additionally, Appellee WAL-MART's attorney of record, Mr. Able, has admitted that "*The State Court Judgment*" is in fact a "*Final Judgment*" against Appellee WAL-MART. Eleventh Circuit Appellee's Motion to Supplement the Record, Page 2.

Based on the foregoing, there could be no stronger or more convincing factual evidence submitted to this Honorable High Court. Eleventh Circuit Panel's assertion that the judgment is not applicable as "Claims Preclusion, Collateral Estoppel and Res Judicata" is clearly erroneous. Estoppel by Judgment: *Firestone v. Pinyan*, 270 S.E.2d 883 (1980). Conflict of Laws Doctrine: *Merchants Home Del. Ser. v. F.B. Hall & Co.*, 50 F.3d 1486 (9th Cir. 1995).

Under Georgia Law, an Order or Judgment that violates "*Due Process of Law*" is a "*VOID JUDGMENT.*" Appellee WAL-MART's assertion that the Third-Party Complaint was transferred to the Superior Court of Fulton County is a Material Misrepresentation of a Material Fact based on the fact that "*Severance of Claims*" resulting from one single incident is not available. Georgia Law forbids severance where a single cause of action is based on agreement that is a "*Joint Obligation*" of the Defendants. *See: Sheffield v. Lewis*, 246 GA 19, 268 S.E.2d 615 (1980). WAL-MART is *Surety* for Lowe and is bound from the beginning, even if the "Surety" is not named within the agreement. *O.C.G.A.* 10-7-4. WAL-MART is an accommodation party. *Surety-O'Leary v. Smith*, 168 S.E.2d 886 (1969).

Appellee WAL-MART's assertion, that all claims were lawfully dismissed within the Superior Court of Fulton County, is factually inaccurate and intentionally misleading.

(vii) Misrepresentation of Material Facts – Professional Misconduct

Agents acting on behalf of Defendant-Appellees have made "Material Misrepresentation of Material Facts," which has effected the outcome of this action.

(viii) False Pleadings and Obstruction of Justice

1. Frivolous denial of the fact that WAL-MART STORES, INC., is "Plan Administrator" under applicable ERISA statutes. Material Misrepresentation of Material Fact, Obstruction. (R1-5), (R2-39); (R1-25), (R1-27).

2. Failure to submit proper "Mandatory Disclosures." Violation of F.R.Civ.P. Rule 26, and Due Process of Law. *Knowing Concealment*, *See:* 151 FRD 147 (1993) (R1-8), (R1-12-14).

REASONS FOR GRANTING THE WRIT

This case presents the question whether an ERISA Plan; lacking fundamental fairness of agreement, based on the fact that said Plan agreement is a "*Contract of Adhesion*," with many of the Plan Provisions unknown to Plan Participants and Beneficiaries, is enforceable without complete disclosure of all Plan Provisions and establishment and identification of the Plan Administrator? The foregoing material facts create the basis for determination of a proper "*Standard of Review*," pursuant to this Court's

ruling in *Firestone* and if Plan is entitled to "summary judgment" without said disclosures in violation of *F.R.Civ.P.* Rule 26(a)(1)? *See:* 151 FRD 147 (1993).

Petitioner seeks review because judgment below:

1. Involves issues of fundamental national importance.
2. Conflicts with this Court's decisions regarding judicial review of ERISA Plans, after establishing the proper "*Standard of Review*" set out in *Firestone*.
3. Works to defeat statutory "ERISA Plan Goals."
4. Violates "*Petitioner's Right to Due Process.*"
5. Causes split between the Circuit Courts as it conflicts with Seventh Circuit "*Bench Trial Rule*" as further established in *WAL-MART v. Wells* (7th Cir. 2000).
6. Claims preclusion and collateral estoppel have been established within U.S. District and Eleventh Circuit Courts.
7. Has resulted in "*Manifest Injustice*" against Plaintiff-Petitioner James C. Lowe.

I. ISSUES RAISED INVOLVE FUNDAMENTAL NATIONAL IMPORTANCE

Petitioner has presented ten questions (page i) which are of fundamental importance regarding all ERISA Plan actions within the State of Georgia and the Eleventh Circuit. These issues also have "*Fundamental National Importance.*"

The uncontrolled proliferation and administration of ERISA Plans creates Plan Administrators, who have no reason to act appropriately, with regard to their Fiduciary Duty to Plan Participants and Beneficiaries, due to the fact that the Courts are not applying *"The Congressional Mandate."*

II. CONGRESSIONAL MANDATE

As further setforth in (page 3 No. 7) the Congressional Mandate is that the ERISA Benefit Plans be administered for sole benefit of the Plan Participants and Beneficiaries, not to preserve "Plan Assets" that revert back to the Plan upon dissolution of the Plan Trust. ERISA 29 U.S.C.A. 1001b(c)(3).

The Courts have disregarded the CONGRESSIONAL MANDATE to the detriment of Plan Participants and Beneficiaries.

III. DENIAL OF DUE PROCESS OF LAW

More ominously Judge Evans of the District Court is ready to grant blanket summary judgment to Defendants regardless of Petitioner's right to Due Process of Law, as guaranteed by the Fifth Amendment of the United States Constitution. Under applicable TRUST LAW Petitioner Lowe's benefits can not be denied, as he is a NON-SIGNATORY-BENEFICIARY-USUFRUCTUARY.

VIOLATIONS OF DUE PROCESS OF LAW were clearly enunciated in Plaintiff-Petitioner's Reply Brief Page 1, filed with the Eleventh Circuit, under designated heading *"ENUMERATION OF ERRORS."*

1. District Court allowed "Defendants" to submit incomplete MANDATORY DISCLOSURES in violation of: F.R.Civ.P. 26(a). (R1-8). The Court DENIED Plaintiff's Motion to compel MANDATORY DISCLOSURES and failed to enter sanctions against Defendants. (R1-14), (R2-32).

2. Plaintiff Lowe's Complaint "Count III" alleges failure to produce ERISA Plan Documents and The District Court would not "COMPEL DISCLOSURE" of ERISA PLAN Documents. Result: Plan Documents could not be fully identified. (R1-1), (R2-37), (R1-14), (R2-32).

3. District Court failed to apply the "*MAKE WHOLE DOCTRINE.*" DOCTRINE applies, when Benefits are initially granted. *Gries v. WAL-MART*, "Unpublished" (11th Cir. 1998) unreported case attached to App.Reply BR. APPENDIX II, pursuant to: Eleventh Circuit (R. 36-2).

4. District Court allowed Defendants to use undisclosed Plan Documents, within their pleadings, and did not establish validity, enforceability or legality of Plan Documents, pursuant to Georgia Law. Petitioner Lowe submits it is unknown, at this juncture, what Documents comprise the WAL-MART ERISA Plan and is appalled at the District Court's willingness to allow Defendants to attempt to enforce provisions of unverified, unenforceable ERISA Documents. F.R.Civ.P. 26(a) and 37(a). (R1-23), (R2-49).

5. District Court ruled that Georgia State Statutory Law is controlling, regarding substantive issues and has failed to even establish which Georgia State Laws are preserved under ERISA, pursuant to The McCarren Ferguson Act, *Conflict of Laws Doctrine* and *Burford* Doctrine. (R3-55), (R3-64) Exhibits "*A*" & "*B*."

6. Plaintiff presented pleadings and exhibits which establish the fact that Defendant WAL-MART Stores, Inc. is "DEFACTO PLAN ADMINISTRATOR" for

WAL-MART STORES INC. ASSOCIATES HEALTH AND WELFARE PLAN. 29 U.S.C.A. 1002(16)(A)(ii). (R1-7 p.2).

7. District Court failed to enter *DEFAULT JUDGMENT* after Notice of Default and Motion. (R2-41), (R2-46).

8. District Court failed to apply *DOCTRINE OF CONTRA PROFERENTUM* to resolve "*AMBIGUITIES IN PLAN DOCUMENTS.*" *Lee v. Blue Cross*, 10 F.3d 1547 (11th Cir. 1994); *Vizcaino v. Microsoft*, 97 F.3d 1187 (9th Cir. 1996).

9. District Court failed to establish the fact that WAL-MART is "*PLAN ADMINISTRATOR,*" which has resulted in application of the wrong "*STANDARD OF REVIEW.*" (R3-55).

10. District Court failed to issue a *PRETRIAL ORDER*, thereby depriving the Court of the best evidence, of controlling applicable Georgia State Statutory Law, after ruling that Georgia Law is controlling, within the action. (R1-26).

11. District Court failed to resolve "*Incongruent Anomalies*" within the WAL-MART Plan Documents and failed to establish surviving Georgia State Statutory Law and then "*Denied*" Referral for Resolution under Federal Arbitration Act. 9 U.S.C.A. 1 *et seq.* (R3-50), (R3-51), (R3-54), (R3-55). *Gilmer v. Int./Johnson Lane Corp.*, 500 U.S. 20.

12. District Court used "*VOID JUDGMENT*" from the State Court and "*RETROSPECTIVE APPLICATION*" of *Cagle v. Brunner* as the two pillars to form the basis for the ruling and judgment of the District Court.

    No "*Retrospective Application*" under Georgia Law. Constitution of Georgia Art. I Sec. I Par. X. (R3-55). *O.C.G.A.* 1-3-5.

    Antony v. Penn., 92 S.E.2d 14 (Ga. 1956).

13. District Court used inappropriate "*Cost Shifting*" and entered Judgment against Plaintiff Lowe for costs. *Davis v. E.I. du Pont de Nemours & Co.*, 176 F.R.D. 224 (1997). (R3-55) App.Br.P.17.

14. District Court consistently ruled against Plaintiff Lowe on "*All Issues*" of "Applicable Substantive & Procedural Law" and used "*Retrospective Application*" to DENY Plaintiff-Petitioner Lowe's lawful right to HEALTH CARE BENEFITS. *Cagle v. Brunner*, decided in 1997.

15. District Court failed to apply "*THE LAW OF TRUSTS*" to Plaintiff Lowe's Claims, as WAL-MART administrators the WAL-MART HEALTH PLAN through a TRUST. Proper application of "TRUST LAW" would result in establishing the incontrovertible fact that Lowe is a "*BENEFICIARY*" of an "IRREVOCABLE TRUST" therefore a TRUST LAW USUFRUCTUARY, whose benefits can not be denied.

(R2-50) Plaintiff Lowe's "Theory of Right of Recovery."

IV. THE RULE OF LAW

Plaintiff-Appellant-Petitioner Lowe submits that the foregoing constitutes "*Prejudice Heretofore Unseen*" in the annals of Federal Jurisprudence. Such blatant abuse of discretion and prejudicial rulings by the District Court has reached a new high in violation of Lowe's CONSTITUTIONAL RIGHT TO DUE PROCESS OF LAW. Furthermore the affirmation of such a "*CONSTITUTIONALLY INFIRMED JUDGMENT,*" by the panel of the Eleventh Circuit reaches beyond all reason and logic.

The affirmation, by the Eleventh Circuit of such a clearly "*CONSTITUTIONALLY INFIRMED JUDGMENT*" brings into question the existence of "*THE RULE OF*

LAW." We either have "Laws and Rules of the Court," which must be obeyed or we don't. Clearly Plaintiff-Petitioner Lowe's right to Due Process of Law has been severely trampled by the District Courts "*Rush to Judgment*" and the "*UNCONSCIONABLE*" Affirmation of said "*Constitutionally Infirmed Judgment,*" by the Eleventh Circuit Court.

V. JUDGMENT CONFLICTS WITH DECISIONS OF THIS COURT

A. Review is Warranted, because the Ruling conflicts with This Courts Opinions of Proper "Procedural Due Process" to be exercised by District Courts, with regard to "Judicial Review" of ERISA Benefit Claims.

B. Ruling conflicts with *Firestone v. Bruch*, U.S. (1989), whereby This Court established parameters for the proper "*Standard of Review*" to be implemented by lower Courts, when reviewing ERISA Claims. Conflicted Administrator subject to "Heightened Arbitrary and Capricious Review." District Court used Arbitrary and Capricious Standard.

VI. JUDGMENT CONFLICTS WITH DECISIONS OF THE ELEVENTH CIRCUIT

A. Review is Warranted, because the Ruling conflicts with Eleventh Circuit Opinions which mandate either "De Novo Review" or application of "Heightened Arbitrary and Capricious Standard of Review." Purpose of ERISA, *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983).

(1). The Ruling conflicts with *Godfrey v. Bell South* (1996), which established mandated: "*De Novo Review*," when conflicts were established, within ERISA Plan Documents. *Bituminous v. Advanced* (1996); *Hunt v. Hawthorn* (1997); *Kunin v. Benefit Trust* (9th Cir. 1990)

(2). The Ruling conflicts with *Newell v. Prudential*, 904 F.2d 644 (1990), which established mandated: "*Heightened Arbitrary and Capricious Standard of Review*," when Conflict of Interest is established, within ERISA Plan Documents. *Brown v. Blue Cross*, 898 F.2d 1556 (1990). *Rosen v. TRW*, 979 F.2d 191 (1992).

VII. JUDGMENT CONFLICTS WITH DECISIONS OF THE SEVENTH CIRCUIT

A. Review is Warranted, because the Ruling conflicts with Seventh Circuit Opinion, which mandates a "*Bench Trial*" on the issues of "*Subrogation and Reduction and Reimbursement*."

(1). The Ruling conflicts with *WAL-MART v. Wells*, (2000), which established mandated "*Bench Trial*" on the issues of Subrogation and Reduction and Reimbursement, due to the fact that "The WAL-MART Plan Documents" failed to provide "*DISCRETION*" to the Plan Administrator, with regard to the foregoing issues.

(2). "*Conflict between the Judicial Circuits*" is one of the primary factors to be considered when decisions to grant Writ of Certiorari is reviewed.

Rules of the Supreme Court, Rule 10(a)

VIII. RULING CONFLICTS WITH GEORGIA STATE STATUTORY LAW AND STATE COURT JUDGMENTS PRESERVED UNDER ERISA

Review is Warranted, because the ruling conflicts with GEORGIA STATE STATUTORY LAW, with regard to the *MAKE WHOLE DOCTRINE* and *ANTI-ASSIGNMENT STATUTE*, regarding proceedings against "Third-Party Tort-Feasors" and also violates "Res Judicata of State Court Judgments," which in turn violates "*The BURFORD DOCTRINE*" (1943).

A. The ruling conflicts with *O.C.G.A.* 33-24-56.1, regarding The Make Whole Doctrine *Gries v. WAL-MART* (11th Cir. 1998). Appellant Lowe's Reply Brief, Appendix II. Make Whole Doctrine, *Guy v. S.E. Iron* (11th Cir. 1989). Promissory Estoppel Doctrine, *Mooney v. Mooney*, 508 S.E.2d 766 (Ga. App. 1998) *Conflict of Laws Doctrine* and *Burford Doctrine*. (R3-57 p.3), Issue raised on Appeal (App.Rep.Br.PP.1 & 5)

B. The Ruling conflicts with *O.C.G.A.* 44-12-24 regarding "*Assignment of the Right of Action*" against Third-Party Tort-Feasors, as interpreted by the SUPREME COURT OF GEORGIA in *Wrightsman v. Hardware Deal. Mut. Inc.*, (Ga. 1966), said ruling is binding on the Eleventh Circuit shown in: *Fed. Ins. Co. v. Travelers*, 280 F.3d 1356 (11th Cir. 2002). *METROPOLITAN, RUSH-PRUDENTIAL, PILOT, UNUM & KENTUCKY ASSOC.*

C. The Ruling conflicts with "Res Judicata and Collateral Estoppel," established within the Georgia State Court Judgment against Defendant WAL-MART, which in turn also violates the *Burford Doctrine*, regarding the States Right to resolve issues of importance to the several States. State

Law to be applied in Federal Actions shown in: *Erie v. Thompkins*, 304 U.S. 64; *Kentucky Assoc. of Health Plans Inc. v. Miller*, No. 00-1471 (2003), *Rules of the Supreme Court*, Rule 10(a)

IX. MANIFEST INJUSTICE

As clearly setforth above, Plaintiff-Petitioner Lowe has submitted numerous, meritorious and compelling reasons for this Honorable High Court of Last Resort to grant Petition for Writ of Certiorari in this case. Petitioner Lowe has made extraordinary efforts to present pertinent, and relevant facts, which establish the basis for his Petition.

Petitioner James C. Lowe's *"RIGHT TO DUE PROCESS OF LAW"* has been violated, resulting in *MANIFEST INJUSTICE* against Petitioner Lowe.

SUMMARY

As a former Insurance Agent for Prudential Insurance Companies of America, I submit that the Eleventh Circuit Panel decision is contrary to the foregoing "binding precedents" of the United States Supreme Court, and Eleventh Circuit Court or otherwise conflicts with other Circuit Courts, applicable Trust Law and State Law. Therefore *this Court* should reverse the decision of the Eleventh Circuit, on the foregoing grounds to secure and maintain uniformity of decisions, regarding ERISA Health Care Benefit Plans.

Denial of Due Process of Law has been clearly established within these pleadings. The District Court failed to

identify the ERISA Plan Administrator, therefore proper Standard of Review could not be established pursuant to *Firestone.*

Additionally, this judgment conflicts with the Seventh Circuit "*Bench Trial Rule*" as articulated in *WAL-MART v. Wells* (2000). Grant of "*Summary Judgment*" improper where "Subrogation and Reduction and Reimbursement" are at issue. *WAL-MART v. Wells.*

Furthermore, "*Claims Preclusion*, "*Collateral Estoppel*" and "*Res Judicata*" have been established within the District Court and Eleventh Circuit Court, through an "*Arbitration Award*" in State Court. *WAL-MART's liability lawfully established.*

Based on the foregoing Plaintiff-Petitioner James C. Lowe submits that the final judgment of The District Court, was affirmed by the Eleventh Circuit Court of Appeals, has resulted in "*MANIFEST INJUSTICE*" against Petitioner Lowe.

Plaintiff-Petitioner James C. Lowe is proceeding "*Pro se*" and is entitled to "Liberal Construction" of his pleadings, pursuant to *Haines v. Kerner*, 404 U.S. 519 (1972).

The "*Hyper-Technical Ruling*," by the Eleventh Circuit Court of Appeals, has violated the spirit of *Haines.* Not only has Petitioner Lowe's "Right to Due Process of Law" been violated by the District Court, the Eleventh Circuit Court has simply failed to rule on core issues, which control this action.

UNRESOLVED ISSUES

1. Establishment of the ERISA Plan Administrator.
2. Validity and Enforceability of Plan Documents.
3. Ruling on Unconscionability of Contract.
4. Application of proper Standard of Review.
5. Establishment of Petitioner Lowe as "Trust Law Beneficiary-Usufructuary."
6. Establishment of Georgia State Law, preserved under ERISA, pursuant to *Kentucky Assoc.*
7. Application of The Make Whole Doctrine.
8. Establishment of Claims Preclusion, Res Judicata and Collateral Estoppel, based on State Court Arbitration Award and Judgment.
9. Ruling on Constitutionality of ERISA.

In any event, the issues presented by this case are ripe for This Courts intervention, whether plenary or summary.

CONCLUSION

The Petition for Writ of Certiorari should be granted in the interest of justice. The Court may wish to consider summary reversal.

Respectfully submitted,

JAMES C. LOWE
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(404) 758-6439

[DO NOT PUBLISH]

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 03-12667
Non-Argument Calendar

D.C. Docket No. 98-01634-CV-ODE-1

JAMES C. LOWE,

Plaintiff-Appellant,

versus

WAL-MART STORES, INC. ASSOCIATES HEALTH AND WELFARE PLAN,
WAL-MART STORES, INC., *et al.*

Defendants-Appellees.

Appeal from the United States District Court for the Northern District of Georgia

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(Filed January 8, 2004)

Before ANDERSON, MARCUS and WILSON, Circuit Judges.

PER CURIAM:

James C. Lowe ("Lowe"), proceeding *pro se*, appeals the district court's grant of summary judgment to Wal-Mart Stores, Inc. Associates Health and Welfare Plan ("the Plan"), Wal-Mart Stores, Inc. ("Wal-Mart"), the Administrative

Committee, and individual officers of the Plan, pursuant to Fed. R. Civ. P. 56, Lowe filed this action pursuant to the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq*,[1] alleging that the defendant-appellees wrongfully withheld benefits owed to him through his wife's ERISA-governed health benefits plan. The district court granted summary judgment to the defendant-appellees, finding that the plan administrator's decision to deny benefits was neither arbitrary nor capricious. Lowe now appeals that decision, arguing that the district court erred by entering summary judgment because (1) it erroneously applied an "arbitrary and capricious" standard to review the plan administrator's decision; (2) there were genuine issues of material fact as to whether the denial of his claims for benefits was arbitrary and capricious; (3) he presented sufficient evidence to establish that the defendants breached their fiduciary duties under the Plan; and (4) decisions in his related state-court lawsuits controlled the outcome of this case and required entry of judgment in his favor. Lowe also asserts that the district court erred by denying his motion to compel discovery prior to granting summary judgment.[2]

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[1] ERISA provides that a "civil action may be brought by a participant or beneficiary . . . to recover benefits due . . . under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B). In this Circuit, this section confers a right to sue the Plan Administrator for recovery of benefits. *See Rosen v. TRW, Inc.*, 979 F.2d 191, 193-94 (11th Cir. 1992).

[2] Lowe argues for the first time on appeal that ERISA, as applied to single employer health care benefit plans, is unconstitutional. Appellate courts generally do not consider an issue or theory that was not raised in the district court, unless: (1) it involves a pure question of law; (2) the appellant had no opportunity to raise the objection below; (3) the interest of substantial justice are at state; (4) the proper resolution is beyond any doubt; or (5) the issue presents significant

(Continued on following page)

We review the grant of summary judgment *de novo*, applying the same standards as the district court. *Loskill v. Barnett Banks, Inc. Severance Pay Plan*, 289 F.3d 734, 736 (11th Cir. 2002), *cert. denied*, 537 U.S. 1167, 123 S.Ct. 965, 154 L. Ed. 2d 908 (2003). Summary judgment should be awarded when "there is no genuine issue as to any material fact and . . . the moving party is entitled to a judgment as a matter of law." *Id.* (citing Fed.R.Civ.P. 56(c)). Viewing the evidence in the light most favorable to the nonmoving party, we ask "whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law." *Id.* We review for abuse of discretion a court's decision to rule on a summary judgment motion without allowing the plaintiff to complete desired discovery. *Leigh v. Warner Bros., Inc.*, 212 F.3d 1210, 1214 (11th Cir. 2000).

Upon thorough review of the record, as well as careful consideration of hte [sic] parties' briefs, we find no reversible error and affirm.

The relevant facts are straightforward. Through his spouse Belinda, an employee at Wal-Mart, Lowe is eligible to be a beneficiary of the Wal-Mart Health Plan (the "Plan"). In 1994, Lowe filed medical claims with the Plan following a car accident which had caused injuries and

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questions of general impact or of great public concern. *See Wright v. Hanna Steel Corp.*, 270 F.3d 1336, 1342 (11th Cir. 2001) (internal citations omitted). Lowe's claims do not satisfy any of these conditions and we therefore do not address them. We also refuse to consider the numerous arguments Lowe asserts for the first time in his reply brief. *See Fogade v. ENB Revocable Trust*, 263 F.3d 1274, 1296 n. 19 (11th Cir. 2001) (stating that arguments raised for the first time in a reply brief are not properly before the Court).

medical expenses in excess of $40,000. Before releasing any benefits, the Plan required Lowe to sign a subrogation and reimbursement agreement, entitled "Subrogation Rights Notification Agreement." Through this agreement, Lowe would acknowledge that he read the Plan Summary Description regarding the Plan's right to reimbursement. Lowe refused to sign the agreement, offering no explanation as to his reasons, so he did not receive any benefits.

Lowe then filed this *pro se* action against the Plan, Wal-Mart, the Administrative Committee, and various individuals, arguing that: the Plan could not condition its distribution of benefits on Lowe's signing a subrogation and reimbursement agreement; the Plan documents were invalid; and the Administrative Committee failed to produce documents as required under ERISA. The district court first held that it was reasonable for a plan to require the execution of a subrogation agreement before paying benefits. Second, Lowe offered no law or facts supporting his allegation of the Plan's invalidity, so the court found the argument without merit. Finally, the district court held that because Lowe never requested Plan documents in writing and did not allege any specific deficiencies in documents obtained by his wife, the defendant-appellees could not be held liable for any failure to provide documents. Therefore, it entered summary judgment for the defendants. This appeal followed.

First, Lowe argues that the district court erred in applying an "arbitrary and capricious" standard to review the Administrative Committee's denial of benefits, and that the court should have reviewed the decision *de novo*. The denial of ERISA benefits is subject to *de novo* review, unless "the benefit plan gives [the Plan's administrator] discretionary authority to determine eligibility for benefits

or to construe the terms of the plan." *Cagle v. Bruner*, 112 F.3d 1510, 1516 (11th Cir. 1997) (internal citations omitted). If discretion exists, the arbitrary and capricious standard of review applies, unless the Plan's construction "would advance a conflicting interest of [the administrator] at the expense of the affected beneficiary." *Id.* If a conflict of interest is shown, the burden shifts to the administrator to demonstrate that its interpretation of the Plan is not tainted by self-interest under a "heightened arbitrary and capricious standard of review." *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1563 (11th Cir. 1990).[3]

Here, the Plan expressly provided that the Administrative Committee, as Plan Administrator ("Administrator"), had the discretion to interpret and apply the terms of the Plan. The summary plan description similarly granted the Administrator discretion, in reviewing claims, to resolve all questions concerning the administration, interpretation, or application of the Plan. Because the Plan unambiguously gave the Administrator "discretionary authority to determine eligibility for benefits or to construe the terms of the plan," the district court did not err in determining that the arbitrary and capricious standard was applicable. *See Cagle*, 112 F.3d at 1516.

Construing his claims liberally, we understand that Lowe also argues that the district court erred in concluding that no genuine issue of material fact existed on whether the denial of his claims for benefits was arbitrary

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[3] As the district court noted, this arbitrary and capricious standard sometimes is used interchangeably with an abuse of discretion standard. *Jett v. Blue Cross & Blue Shield of Ala., Inc.*, 890 F.2d 1137, 1139 (11th Cir. 1989).

or capricious. *See Haines v. Kerner*, 404 U.S. 519, 520, 92 S. Ct. 594, 596, 30 L. Ed. 2d 652 (1972) (holding *pro se* complaints to less stringent standards than formal pleadings drafted by lawyers). Under the arbitrary and capricious standard of review, the court was limited to deciding whether the Administrator's interpretation of the plan was made "rationally and in good faith." *See Blank v. Bethlehem Steel Corp.*, 926 F.2d 1090, 1093 (11th Cir. 1991). Factors relevant to that determination included: (1) the uniformity of the Administrator's construction; (2) the reasonableness of its interpretation; and (3) possible concerns with the way unexpected costs may affect the future financial health of the Plan. *See id.*

In examining similar plan documents in *Cagle*, which granted the administrator discretion to demand participants and beneficiaries to sign subrogation agreements, we determined that the administrator had uniformly interpreted the plan to provide itself with a right of subrogation to recovery obtained from an at-fault third party, that this interpretation was reasonable, and that the subrogation agreements advanced genuine cost concerns for the plan. *Cagle*, 112 F.3d at 1517-18. We also concluded that it was not arbitrary and capricious for the administrator to require participants to sign its subrogation agreement before paying benefits, instead of later. *Id.* at 1519. We reasoned that the administrator's failure to always require a signed subrogation agreement before payment of benefits was not dispositive because the plan left the exercise of that right in the administrator's discretion not to exercise in circumstances where it appeared unnecessary. *Id.* at 1519-20. In addition, we found that the administrator's interpretation was reasonable and supported by practical reasons, namely that participants and

beneficiaries would have little incentive to sign the form after benefits had been paid. *Id.* at 1520.

In the district court, Lowe argued that the Administrator inconsistently paid on some of his claims before requiring that he sign the subrogation form. Examining the language in the Plan and applying *Cagle*, however, the district court correctly concluded that this fact did not evidence an inconsistent interpretation of the Plan and that it was reasonable to require Low [sic] to sign an agreement before receiving benefits.[4]

We are likewise unpersuaded by Lowe's argument that the Defendants breached their fiduciary duty to provide him with requested documents in conformity with ERISA. ERISA provides that "a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries . . . for the exclusive purpose of . . . providing benefits to participants and their beneficiaries . . . with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims." 29 U.S.C. § 1104(a)(1)(A) & (B). ERISA defines a fiduciary with respect to a plan as someone who has discretionary authority over the administration of the plan. *See* 29 U.S.C.

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[4] Lowe's reliance on *Springer v. Wal-Mart Associates' Group Health Plan*, 714 F.Supp. 1168 (N.D. Ala. 1989), is misplaced. That case involved an agreement that called for the claimant to make reimbursements not required in the then-existing plan. *See id.* at 1177. Moreover, in *Springer v. Wal-Mart Associates' Group Health Plan*, 908 F.2d 897 (11th Cir. 1990), we reversed the district court's opinion after finding that the claimant had failed to exhaust her administrative remedies. *See id.* at 901.

§ 1002(21)(A). ERISA also provides that a fiduciary who breaches its responsibilities shall be personally liable to return any losses incurred as a result of the breach to the plan. *See* 29 U.S.C. § 1109(a); *Hamilton v. Allen-Bradley Co., Inc.*, 244 F.3d 819, 825 (11th Cir. 2001). Moreover, a fiduciary must ~~give complete~~ and accurate information in response to participants' questions. *Hamilton*, 244 F.3d at 827. Notwithstanding these duties, ERISA specifies that the administrator only must furnish, *on written request*, information on the operation of the plan. *Id.* (citing to 29 U.S.C. § 1024(b)(4)).

Here, similar to the facts in *Hamilton*, Lowe did not present a written request for documents and therefore the Plan did not have a fiduciary duty to produce them. To the extent Lowe attempts to challenge the Plan's responses to his spouse's written requests for information, he has failed to identify how the responses were inadequate. On this record, the court did not err in granting summary judgment for the Plan on Lowe's breach-of-fiduciary-duty claim.

Next, Lowe argues that related state cases and this case involve the same facts, were the result of his underlying accident, and present similar issues of law, such that an alleged state arbitration award's conclusion that Lowe was entitled to receive benefits from the Plan is controlling in his federal case. If subsequent litigation arises from a different cause of action, the prior judgment, under issue preclusion (collateral estoppel), bars litigation only of those matters or issues common to both actions, which were either "expressly or by necessary implication adjudicated in the first." *Christo v. Padgett*, 223 F.3d 1324, 1338 n.46 (11th Cir. 2000), *cert. denied*, 531 U.S. 1191, 121 S. Ct. 1190, 149 L. Ed. 2d 106 (2001). To claim the benefit of

issue preclusion, a party must show: "(1) the issue at stake is identical to the one involved in the prior proceeding; (2) the issue was actually litigated in the prior proceeding; (3) the determination of the issue in the prior litigation must have been a critical and necessary part of the judgment in the first action; and (4) the party against whom collateral estoppel is asserted must have had a full and fair opportunity to litigate the issue in the prior proceeding." *Id.* at 1339 (internal quotation marks and citation omitted).

As the district court noted, it was unclear from the state court's summary grant of summary judgment to Defendants whether the claims at issue in this case actually were litigated in that proceeding. Moreover, in another of the state proceedings, after Lowe's state cases were severed, the Defendants as third-party defendants were removed from the arbitration case and ultimately granted summary judgment. Accordingly, Lowe did not show that Defendants had a "full and fair opportunity to litigate the claim" in the prior state proceeding. *See id.*; *see also Shields*, 228 F.3d at 1288.

Finally, Lowe argues that the district court erred in denying his motion to compel discovery before granting summary judgment, despite Defendants' failure to file proper mandatory disclosures and to supplement these disclosures when Lowe notified the court that they were deficient. Federal Rule of Civil Procedure 56(f) allows courts to defer ruling on summary judgment motions until the non-moving party has been able to conduct all necessary discovery. *See* Fed. R. Civ. P. 56(f). While it generally is inappropriate for a court to rule on a summary judgment motion when the non-moving party has been unable to obtain discovery, we have refused to "adopt [a] blanket prohibition on the granting of summary judgment motions

before discovery." *Reflectone, Inc. v. Farrand Optical Co., Inc.*, 862 F.2d 841, 843 (11th Cir. 1989). A party seeking to use Rule 56(f) "may not simply rely on vague assertions that additional discovery will produce needed, but unspecified, facts, but rather he must specifically demonstrate how postponement of a ruling on the motion will enable him, by discovery or other means, to rebut the movant's showing of the absence of a genuine issue of fact." *Reflectone*, 862 F.2d at 843 (internal citations omitted).

Lowe filed a motion to compel, pursuant to Fed. R. Civ. P. 26, in which he claimed that, as evidenced by his amended responses to mandatory disclosure, he was unable to produce critical evidence about individual defendants and original Plan documents, because this discovery was in Defendants' possession. Before granting summary judgment, the court denied Lowe's motion to compel discovery, concluding that Defendants had complied with Rule 26 and were not required to make further disclosures unless Lowe filed specific discovery requests.

The record does not reflect that Lowe filed specific discovery requests on which the district court could have based an order compelling discovery. Moreover, Lowe has not identified specifically on appeal what documents or discovery he was denied or how the court's grant of his motion to compel would have allowed him to rebut the movant's showing of the absence of a genuine issue of fact. *See Reflectone*, 862 F.2d at 843 (stating that movant "may not simply rely on vague assertions that additional discovery will produce needed, but unspecified facts"). Accordingly, the court did not abuse its discretion in denying Lowe's motion to compel discovery prior to granting summary judgment.

On this record, we are satisfied that the plan administrator's denial of benefits was neither arbitrary nor capricious. We accordingly affirm the district court's grant of Defendants' motion for summary judgment.

AFFIRMED.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

James C. Lowe, Plaintiff, vs. Wal-Mart Stores, Inc., et al, Defendants.	CIVIL ACTION FILE NO. 1:98-cv-1634-ODE

JUDGMENT

This action having come before the court, Honorable Orinda D. Evans, United States District Judge, for consideration of defendants' motion for summary judgment, and the court having granted said motion, it is

Ordered and Adjudged that the plaintiff take nothing; that the defendants recover their costs of this action, and the action be, and the same hereby, is **dismissed**.

Dated at Atlanta, Georgia, this 24th day of June, 2002.

LUTHER D. THOMAS
CLERK OF COURT

By: /s/ Frances M. McNulty
Frances M. McNulty,
Deputy Clerk

Prepared, Filed, and Entered
in the Clerk's Office
June 25, 2002
Luther D. Thomas
Clerk of Court

By: /s/ Frances M. McNulty
Deputy Clerk

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF GEORGIA ATLANTA DIVISION

JAMES C. LOWE,

Plaintiff

v.

WAL-MART STORES, INC., as "de facto plan administrator," DAVID D. GLASS, JOHN B. MENZER, PAUL R. CARTER, JOSEPH S. HARDIN, JR., ADMINISTRATIVE COMMITTEE,

Defendants

CIVIL ACTION NO. 1:98-CV-1634-ODE

ORDER

(Filed Jun. 24, 2002)

This case alleging violations of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq.*, is presently before the court on Defendants' motion for summary judgment, Plaintiff's cross-motion for summary judgment, Plaintiff's motion to refer this matter to arbitration, and Plaintiff's motion for oral hearing. All motions are opposed and Plaintiff is appearing *pro se*. For the reasons set forth below, Defendants' motion for summary judgment is GRANTED. Plaintiff's cross motion for summary judgment is DENIED and Plaintiff's remaining motions are DISMISSED as MOOT.

Plaintiff and his wife were in a car accident in 1994 and as a result of that accident, incurred injuries and medical expenses in excess of $40,000. Plaintiff and his wife settled with the driver of the other car who was

responsible for the accident. Plaintiff is eligible to be a beneficiary of the Wal-Mart Health Plan because his wife is an employee at Wal-Mart. At some point after the accident, the Wal-Mart Health Plan (the "Plan") sent Plaintiff a subrogation and reimbursement agreement, entitled "Subrogation Rights Notification Agreement," that serves as an acknowledgment that the Plan beneficiary or participant has read the Plan Summary Description section pertaining to the Plan's right to reimbursement. Plaintiff has refused to execute the subrogation and reimbursement agreement, and as a result, Defendants have refused to pay certain of Plaintiff's medical bills. Throughout the time that this matter has been pending, Plaintiff has not offered any explanation for his refusal to sign the subrogation agreement.

Plaintiff seeks to recover benefits that he claims are being wrongfully withheld by Defendants. Plaintiff also claims that the Plan documents are invalid and that Defendants have failed to produce documents to which he is entitled under ERISA. Defendants have counter-claimed against Plaintiff, asserting a claim for reimbursement should Plaintiff prevail on the merits of his claims.

In May, 1999, the undersigned issued a stay of proceedings in this matter pending resolution of two related cases in the Fulton County Superior Court. At that time, the court ordered a stay until such time as the parties showed that the Fulton County Superior Court had ruled on whether the Plaintiff is precluded from recovering from the Plan as a result of his refusal to sign the subrogation and reimbursement agreement. Defendants have since shown the court that Judge Wendy Shoob on the Fulton County Superior Court granted summary judgment to Wal-Mart in both of the related cases. Judge Shoob's order

did not include findings of fact or conclusions of law, so that the court does not know whether she ruled on the specific issue in question.[1] In the interest of judicial economy, however, the court hereby dissolves the stay and will proceed to a determination of the parties' motions on the merits.[2]

Defendants have moved for summary judgment on all of Plaintiff's claims. In addition to his response to Defendants' motion, Plaintiff has filed a cross-motion for summary judgment on his claims, a motion for oral hearing and a motion for referral to arbitration. Summary judgment is appropriate only "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). In ruling on the movant's motion, the court must view the evidence in a light most favorable to the

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[1] The order stated "[b]ased on the issues and argument, the Court grants the Defendants' motions for summary judgment on the grounds asserted . . . " without explicitly stating those grounds. Defendant did not present to this court an argument on issue or claim preclusion on the question of whether Plaintiff was precluded from recovery due to his refusal to sign the agreement. Rather, Defendants simply reinstated their previously filed summary judgment motion. Without information from the parties as to the issues actually before and decided by the Fulton County Superior Court, the undersigned cannot rely upon that court's grant of summary judgment to dispose of this matter on the basis of preclusion.

[2] Plaintiff contends that the Fulton County orders were obtained through fraudulent conduct by Defendants. This statement is thoroughly unfounded. Plaintiff does not explain what actions by Defendants he considers to constitute such fraud, what effect those alleged actions had on the Superior Court's order, nor does Plaintiff offer any evidence other than his own unsupported statement.

non-movant. *Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 157 (1970). To prevail on its motion for summary judgment, the movant must show that the evidence is insufficient to establish an essential element of the non-movant's case. *Celotex Corp. v. Catrett*, 477 U.S. 317, 325 (1986).

If the movant makes a sufficient showing, then the non-movant "must come forward with 'specific facts showing that there is a genuine issue for trial.'" *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986) (quoting Fed. R. Civ. P. 56(e)). If the evidence supporting the non-movant's claims is insufficient for a jury to return a verdict for the non-movant, or is "merely colorable" or "not significantly probative," then the movant is entitled to summary judgment. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 249 (1986). If, however, reasonable minds could differ as to the import of the evidence, and a reasonable interpretation of the evidence could lead to a verdict for the non-movant, then summary judgment as inappropriate. *Id.* at 251-52.

Plaintiff's first cause of action is for improper denial of benefits under 29 U.S.C. § 1132(a)(1)(B)(2) ("A civil action may be brought by a . . . beneficiary . . . to recover benefits due him under the terms of his plan . . . "). Defendants maintain that because Plaintiff refused to execute the subrogation form, the Plan administrator[3] had discretion to deny Plaintiff's claim for benefits. ERISA does not set

[3] There is some dispute between the parties as to who is actually the Plan administrator. Whether Wal-Mart or the Administrative Committee is, in fact, responsible for administering the Plan is irrelevant to the pending motions, so the court uses the term "plan administrator" generically to describe whichever party in fact administers the Plan.

forth the standard of review by which courts reexamine the claims decisions of a plan administrator. As such, three standards of review of administrator decisions have been judicially crafted for cases alleging a denial of benefits under an ERISA-covered plan: "(1) *de novo* where the plan does not grant the administrator discretion; (2) arbitrary and capricious when the plan grants the administrator discretion; and (3) heightened arbitrary and capricious where there is a conflict of interest." *Whatley v. CNA Ins. Companies*, 189 F.3d 1310, 1313 (11th Cir. 1999). The arbitrary and capricious standard applied when the plan administrator has discretion is used interchangeably with an abuse of discretion standard. *See Jett v. Blue Cross and Blue Shield of Ala., Inc.*, 890 F.2d 1137, 1139 (11th Cir. 1989).

Defendants contend that the Wal-Mart Plan explicitly grants the plan administrator discretion to interpret the Plan and deny benefits based on a beneficiary's failure to sign the subrogation agreement, so that the court would review the decision using the abuse of discretion standard. Plaintiff claims, on the other hand, that the language of the Plan is ambiguous, and therefore insufficient to grant the plan administrator discretion, requiring a *de novo* review.[4] The Plan provides as follows:

> The PLAN herein *expressly gives the ADMINISTRATIVE COMMITTEE discretionary authority to resolve all questions concerning the administration, interpretation or application of the PLAN, including, without limitation, discretionary authority to determine eligibility for benefits*

[4] There is no evidence before the court that there is any conflict of interest requiring the heightened arbitrary and capricious standard.

> or to construe the terms of the PLAN in conducting the review of the appeal. When making its initial determination pursuant to the claim denial and appeals section of this PLAN document, the PLAN shall also have such discretionary authority.

["Wal-Mart Associates' Group Health Plan Document" at p.55, emphasis added]. Moreover, the summary plan description includes the following subrogation clause, entitled "Right to Reduction and Reimbursement:"

> The Plan has the right to reduce or deny benefits otherwise payable by the Plan or to recover benefits previously paid by the Plan to the extent of any and all of the following payments, regardless of whether such payments are designated as payment for but not limited to, pain and suffering, loss of income, medical benefits, or other specified damages and regardless of whether the participant has been made whole . . . :
>
> * Any judgment, settlement, or any payment, made or to be made by a person considered responsible for the condition giving rise to the medical expense or by their insurers.
>
> * Any auto or recreational vehicle insurance coverages or benefits including, but not limited to, uninsured motorist coverage.
>
> * Business and homeowners medical insurance coverage or payments.
>
> * The Plan may request that you or your covered dependant cooperate to guarantee reimbursement to the Plan from third party benefits. *Failure to comply with this request will entitle the Plan to withhold benefits due you under the Plan Document.* You or your covered dependents may

> not do anything to hinder reimbursement of overpayment to the Plan after you have accepted benefits.

[Summary Plan Descr., p. D-8, emphasis added]. A court will review a plan administrator's benefits eligibility decision for abuse of discretion only if "the plan expressly provides the administrator discretionary authority to make eligibility determinations or to construe the plan's terms." *Kirwan v. Marriott Corp.*, 10 F.3d 784, 788 (11th Cir. 1994). The language of the Plan document clearly does exactly that. Accordingly, the court will review the denial of benefits for abuse of discretion.

Plaintiff contends that the denial of benefits constituted an abuse of discretion because the decision to require that Plaintiff sign the subrogation form before paying benefits was inconsistently applied. It is a correct statement of this Circuit's law that an inconsistent exercise of discretion may be evidence of arbitrary decision-making in abuse of that discretion. *See Cagle v. Bruner*, 112 F.3d 1510 (11th Cir. 1997). When reviewing a benefits determination under the abuse of discretion standard, "the function of the court is to determine whether there was a reasonable basis for the decision, based upon the facts as known to the administrator at the time the decision was made." *Jett*, 890 F.2d at 1139. The court considers three factors in determining whether a plan administrator's decision was made rationally and in good faith: "(1) the uniformity of the [plan's] construction; (2) the reasonableness of its interpretation; and (3) possible concerns with the way unexpected costs may affect the future financial health of the [plan]." *Cagle*, 112 F.3d at 1518 (citing *Blank v. Bethlehem Steel Corp.*, 926 F.2d 1090 (11th Cir. 1991).

In this case, Plaintiff maintains that the Plan paid certain claims he submitted before sending him the subrogation form and requiring him to sign it. As evidence, Plaintiff has provided the court with copies of documents entitled "Explanation of Benefits for Provider," which appear to reflect payment by the Plan to various medical providers around the time of the accident. Neither party has explained to the court what medical services are represented by these documents, nor even whether these medical services are related to treatment arising from the accident. Assuming, however, that these "explanations of benefits" reflect payment of some medical treatment required because of the accident, this evidence alone is insufficient to show that the plan administrator abused its discretion in denying benefits.

In *Cagle*, an ERISA health plan denied benefits to the dependent child of a participant because the participant refused to sign an unaltered subrogation agreement. *See Cagle*, 112 F.3d at 1513. Each time the plan sent the participant a subrogation form to sign, she signed it, and added language attempting to limit it. *See id.* The plan there admitted that it did not always require participants to sign the subrogation agreement, but only did so when the plan determined it was necessary. The participant argued there, as Plaintiff argues here, that this seeming inconsistency showed a lack of "uniform construction" of the Plan. *See id.* at 1519. The United States Court of Appeals for the Eleventh Circuit concluded that the plan administrator "has uniformly interpreted the plan to *allow* it to require a signed subrogation agreement before paying benefits," *id.* at 1520 (emphasis added), so that the discretion granted the plan administrator included when to require execution of a subrogation agreement.

In the case at bar, as in *Cagle*, the Plan language "fully recognizes its right to insist upon a signed subrogation agreement as a prerequisite to receiving benefits, but also withholds the exercise of that right in circumstances where it does not appear to be necessary to protect" its assets. *Id.* Thus, the plan administrator may withhold benefits for failure to execute required documentation, but is not required to do so. This also has been the consistent interpretation by the Plan. [*See* Herbaugh Aff. ¶ 14]. In addition, the Plan also clearly grants the administrator discretion in determining all questions regarding interpretation or implementation of the Plan. This broad grant of discretion would include the discretion to determine when to require execution of a subrogation agreement. Once the Plan has determined that it is appropriate to require Plaintiff to execute the subrogation agreement, the Plan also clearly gives the plan administrator the right to deny benefits due to Plaintiff's refusal to execute the agreement.

Moreover, when considering the other factors, namely, concerns about the effects of unexpected costs to the Plan and the overall reasonableness of Defendants' interpretation, the court concludes that the Plan did not abuse its discretion by denying benefits. The court in *Cagle* made clear that a plan may require the execution of a subrogation agreement before paying benefits, concluding specifically that such a requirement is reasonable in light of the "practical reasons" underlying that policy decision. *See Cagle*, 112 F.3d at 1520. Thus, considered in the light most favorable to him, Plaintiff's evidence still is insufficient to show that the plan administrator abused its discretion by denying the claims.

Finally, Plaintiff maintains that the "make whole" doctrine requires Defendants to continue to pay benefits,

having already paid some of the submitted claims. The make whole doctrine provides that an insured is liable to the insurer for subrogation only to the extent of excess received over the amount of the total loss. *See id.* at 1520. Assuming, *arguendo*, that the make whole doctrine could be applicable here, an ERISA plan can override the whole doctrine with language that specifically allows "the plan the right of first reimbursement out of any recovery the participant was able to obtain even if the participant were not made whole." *Id.* at 1522 (citation and internal punctuation omitted). In the case at bar, the Plan provides that the Plan has the right to reimbursement for recovery from third parties "regardless of whether the participant has been made whole." Accordingly, the Plan has effectively contracted out the make whole doctrine.

The court now turns to Plaintiff's claim that the Plan documents "failed to grant lawfully enforceable provisions to the plan administrator and/or de facto plan administrator." [Pl. Am. Compl. ¶ 22]. Plaintiff contends that various Plan documents are ambiguous, internally inconsistent, or confer "mutually exclusive" rights making the Plan unenforceable. [*See* Pl. Am. Compl. Count II]. As Plaintiff failed to substantiate such allegations with law or facts, the court finds the argument without merit.

Finally, the court considers Plaintiff's claim that the Plan has failed to produce documents upon request in violation of 29 U.S.C. §§ 1021(a) and 1132(c). ERISA confers upon plan participants a right to certain information, which the Plan must provide to the participant upon request. *See* 29 U.S.C. § 1021(a). Assuming, although the record is far from clear, that the information that Plaintiff seeks is included in that information to which a participant is entitled under ERISA, the parties agree that

Plaintiff is not a participant in the Plan, but is a covered dependent beneficiary. The parties also agree that Plaintiff's wife, who is the Plan participant, wrote to the Plan on three occasions requesting the information that Plaintiff now claims Defendants failed to produce. Defendants maintain, and Plaintiff does not dispute, that Defendants timely replied to Mrs. Lowe's written requests for information. Defendants' response is further evidenced by the fact that Plaintiff has attached or referenced Plan information of which he clearly has possession. The parties further agree that Plaintiff himself never wrote to Defendants, requesting information. Plaintiff maintains that he never did so because, as a beneficiary rather than a participant, he had no right to request the information. If, however, he had no right to request the information, then he has no ERISA cause of action for Defendants' failure to produce it. To the extent that Defendants failed to provide required information to Mrs. Lowe upon her request as a participant in the Plan, the court points out that Mrs. Lowe is not a party to this litigation, and Plaintiff cannot properly state a claim for injury to her. To the extent that Plaintiff did, in fact, have a right to receive information as a Plan beneficiary, he never requested it in writing, and therefore Defendants cannot be held liable for any failure to provide it.

Plaintiff contends, however, that he has made "heroic efforts to secure unabridged, relevant and pertinent 'Plan documents' and related Plan materials" and that he "has been thwarted at every turn by the obstinate and stubborn failure and refusal of the Defendants to provide certified, unabridged, unredacted and otherwise uncompromised Plan documents." [Pl. Brf. in Supp. of Rsp. to Def. Mot. for S.J., p. 1]. Thus, the court understands Plaintiff to claim

that the documents provided to his wife in response to her request were incomplete, altered, or compromised in some way. Assuming Plaintiff has some kind of derivative standing to bring such a claim, Plaintiff does not identify which documents have been altered, what information is missing from the materials provided by Defendants or otherwise specifically described the information that he thinks Defendants are keeping from him. Plaintiff's allegation that Defendants have provided altered or incomplete information is entirely unsubstantiated and therefore is without merit.

Accordingly, Defendants' motion for Summary Judgment [49] is therefore GRANTED. In light of the disposition above, it is clear that Plaintiff cannot recover on his claims so that Plaintiff's cross-motion for summary judgment [50-1] is DENIED. Plaintiff's motion for oral hearing [50-3] and motion for referral to arbitration [50-2] are DISMISSED as MOOT.

SO ORDERED, this 24 day of June, 2002.

/s/ Orinda D. Evans
ORINDA D. EVANS
UNITED STATES DISTRICT JUDGE

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

JAMES C. LOWE Plaintiff v. WAL-MART STORES, INC., ASSOCIATES HEALTH AND WELFARE PLAN; and WAL-MART STORES, INC., DAVID D. GLASS, JOHN B. MENZER, PAUL R. CARTER, JOSEPH S. HARDIN, JR., as PLAN TRUSTEES; and THE ADMINISTRATIVE COMMITTEE, as PLAN ADMINISTRATOR, Defendants	CIVIL ACTION NO. 1:98-CV-1634-ODE

ORDER

(Filed Feb. 10, 1999)

This *pro se* civil action, filed pursuant to the Employee Retirement Income Security Act ("ERISA") 29 U.S.C. § *et seq.*, is currently before the court on the following motions: Defendants' motion to dismiss Wal-Mart Stores Inc. ("Wal-Mart") as a Defendant, to dismiss Plaintiff's claims for extra contractual damages, and motion for a more definite statement as to Count II; Plaintiff's motion for reclassification of Defendant Wal-Mart as a de facto Plan Administrator; Plaintiff's motion for leave of court to file amended and supplemented complaint; Plaintiff's "emergency motion" to compel disclosure; Plaintiff's motion for oral

argument (captioned "motion for oral hearing"); and cross motions for sanctions.

Plaintiff is the spouse of Belinda Lowe, a Wal-Mart employee. It is undisputed that the Lowes are eligible to become participants in the Wal-Mart Associates' Group Health and Welfare Plan ("Plan"). Defendants argue that Plaintiff is currently ineligible to recover Plan benefits because he refused to sign the Plan's reimbursement and subrogation form, a prerequisite of the Plan.

Plaintiff seeks to recover benefits under the Plan, which he claims were wrongfully denied. Plaintiff also asserts that the Plan documents are invalid. Plaintiff seeks compensatory damages and relief for mental anguish and emotional distress.

The court will consider Defendants' motion to dismiss Wal-Mart as a Defendant in conjunction with Plaintiff's motion to reclassify Defendant Wal-Mart as a de facto Plan Administrator and motion for leave to amend the complaint. In their motion to dismiss, Defendants contend that Defendant Wal-Mart is not a proper party as it is not the Plan Administrator or the Plan and an ERISA action may only be maintained against the Plan or the Plan Administrator.

> ERISA provides that a money judgment against an employee benefit plan is only enforceable against the plan as an entity, unless liability against some other person is established. Liability against some other person can be established by proof that the person is a plan administrator and thus responsible for decisions regarding benefits.

Rosen v. TRW, Inc., 979 F.2d 191, 192 (11th Cir. 1992). Plaintiff's complaint does not allege that Wal-Mart is the Plan Administrator, but that it is the Plan sponsor. In order to remedy this situation, Plaintiff seeks to have Defendant Wal-Mart reclassified as a "de facto Plan Administrator." In assessing Plaintiff's claim against Wal-Mart, the court is mindful that "[a] complaint may not be dismissed under Fed. R. Civ. P. 12(b) (6) 'unless it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief.'" *Rosen v. TRW, Inc.*, 979 F.2d 191, 194 (11th Cir. 1992) (quoting *Conley v. Gibson*, 355 U.S. 41, 45-46 (1957)).

Plaintiff contends in his amended complaint that he has received documents from the United States Department of Labor which "lead Plaintiff to believe that Wal-Mart is in fact the De Facto Plan Administrator for [the] Health Plan." [Plaintiff's Amended complaint at 9]. "If a company is administrating the plan, then it can be held liable for ERISA violations regardless of the provisions of the plan document." *Rosen*, 979 F.2d at 193-194. The court cannot conclude at this stage that Plaintiff "will be unable to prove that the company may be properly regarded as the plan administrator." *Id.* at 194. Therefore, Defendants' motion to dismiss Defendant Wal-Mart is DENIED. Plaintiff's motion for leave to amend the complaint is GRANTED only insofar as Plaintiff seeks to reclassify Defendant Wal-Mart as a de facto plan administrator. Plaintiff is DIRECTED to submit an amended complaint, in its entirety, so stating, within twenty (20) days of the entry of this order.

Defendant also seeks to dismiss Plaintiff's claims for extra contractual damages, as they are not available under ERISA. In his prayer for relief, Plaintiff seeks "other

equitable relief" which is fully set out in Count V of the complaint. Specifically, Plaintiff states, inter alia, that he suffered: "irreparable harm, humiliation, mental anguish, and also emotional and physical distress, and has been injured in mind and body himself and his family have [sic] suffered indignity due to the wrongful acts" of Defendants. [Plaintiff's complaint at ¶ 31]. Moreover, Plaintiff asserts that Defendants' conduct has been "malicious and oppressive." [Plaintiff's complaint at ¶ 35]. It appears that Plaintiff seeks compensatory and punitive damages in addition to equitable relief; however, while a plan beneficiary can sue to enforce his rights under the plan and to obtain equitable relief, he cannot sue for punitive or compensatory damages. *Cooper v. Smith*, 89 F.3d 755, 761 (11th Cir. 1996). Therefore, Defendants' motion to dismiss Plaintiff's claims for extra contractual damages is GRANTED.

Defendant moves for a more definite statement as to Count II of Plaintiff's complaint in which he alleges that the Plan documents are invalid. Defendants seek Plaintiff to describe the allegedly invalid documents and state how they are purportedly unlawful. Federal Rule 12(e) provides that a more definite statement is warranted, "if a pleading is so vague or ambiguous that a party cannot reasonably be required to frame a responsive pleading." Upon review of the complaint, Plaintiff merely alleges that the Plan documents are "legally unenforceable." Such bare allegations warrant a more definite statement. Plaintiff shall furnish a more definite statement as to Count II wherein Plaintiff describes the documents he contends are invalid and states how they are unlawful within twenty [20] days of the entry of this order.

The court now turns to Plaintiff's motion to compel disclosure and motion for sanctions. While it is unclear from Plaintiff's motion, it appears that Plaintiff contends that Defendants have not furnished the requisite discovery and information in their responses to mandatory disclosures. Plaintiff contends that, in his own amended responses to mandatory disclosures, he "specifically identified relevant, pertinent, tangible discoverable items, individuals and things" he seeks to which Defendants have not responded. Defendants argue that they have filed sufficient responses to the mandatory disclosures and that they have not learned that their mandatory disclosures are incomplete or incorrect. Defendants contend that because Local Rule 26.1 provides specific mandatory disclosures to be answered by Defendants, they need not furnish any additional information until Plaintiff issues specific discovery requests.

Federal Rule 26(a)(1) provides that a party shall, without awaiting discovery:

> (A) provide the name, and if known, address and telephone number of each individual likely to have discoverable information relevant to disputed facts alleged with particularity in the pleadings;
>
> (B) a copy of, or a description by category and location of, all documents, data compilations, and tangible things in the possession, custody, or control of the party that are relevant to disputed facts.

The disclosure provisions of Fed. R. Civ. P. 26(a) (1) (2) are incorporated into Local Rule 26.1(A) at mandatory interrogatories 5, 6 and 7. Therefore, Defendants are required to comply with Fed.R.Civ.P. 26a(1) (A) and (B).

That said, upon review of the record, it appears that Defendants have sufficiently complied with the Federal and Local Rule disclosure requirements and they need not furnish any additional information until Plaintiff issues specific discovery requests. Plaintiff has not issued any discovery requests. Plaintiff's own Amended Mandatory Disclosures do not serve as a discovery request and any attempt to so utilize is improper. Therefore, Plaintiff's motion to compel is DENIED. The court does not find that either motion for sanctions is justified at this time.

Accordingly, Defendant's motion to dismiss Defendant Wal-Mart [#6-1] is DENIED. Plaintiff's motion to reclassify Defendant Wal-Mart as a de facto Plan Administrator [#15-1] is hereby GRANTED. Plaintiff's motion for leave to amend the complaint [#15-2] is GRANTED. Defendants' motion to dismiss Plaintiff's claims for extra contractual damages [#6-2] is GRANTED. Defendant's motion for a more definite statement as to Count II [#6-3] is GRANTED. Plaintiff's motion to compel [#14-1] is DENIED. Plaintiff's motion for sanctions [#14-2] is DENIED. Defendant's motion for sanctions [#16] is DENIED. Plaintiff's motion for oral argument [#18] is DENIED.

SO ORDERED, this 10 day of February, 1999.

/s/ Orinda D. Evans
ORINDA D. EVANS
UNITED STATES
DISTRICT JUDGE

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF GEORGIA ATLANTA DIVISION

JAMES C. LOWE Plaintiff v. WAL-MART STORES, INC. ASSOCIATES HEALTH AND WELFARE PLAN; WAL-MART STORES, INC.; DAVID D. GLASS, JOHN B. MENZER, PAUL R. CARTER, JOSEPH S. HARDIN, JR., as PLAN TRUSTEES; and THE ADMINISTRATIVE COMMITTEE, as PLAN ADMINISTRATOR, Defendants	)	CIVIL ACTION NO. 1:98-CV-1634-ODE

ORDER

(Filed May 24, 1999)

This *pro se* civil action, filed pursuant to the Employee Retirement Income Security Act ("ERISA") 29 U.S.C. § 1001 *et seq.*, is currently before the court on its own motion to consider whether the instant action should be stayed pending resolution of proceedings in the State Court of Fulton County and the Superior

Court of Fulton County.[1] A hearing was held in chambers on March 17, 1999.

Plaintiff and his wife were in a car accident in 1994 and as a result of that accident, incurred injuries and medical expenses in excess of $40,000. Plaintiff and his wife received a settlement check from the insurer of the tortfeasor (the individual driving the other car). Plaintiff is eligible to be a beneficiary of the Wal-Mart Health Plan because his wife is an employee at Wal-Mart. Plaintiff has refused to execute the Wal-Mart Health Plan's subrogation and reimbursement agreement, and as a result, Defendants have refused to pay Plaintiff's medical bills.

Columbia West Paces Ferry Medical Center and Center Neurology, P.C. have filed collections actions against Plaintiff in the Superior Court and State Court of Fulton County, respectively, in order to recover money due for medical services provided to Plaintiff after the accident.[2] Plaintiff has, in turn, joined Defendants Wal-Mart Stores Inc. and Wal-Mart's Health Plan as third-party Defendants in the collection actions. It is

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[1] *Columbia West Paces Ferry Medical Ctr. v. James C. Lowe v. Wal-Mart Stores Inc., d/b/a Wal-Mart Health Care*, Case No. 96-VS-0113449-JJ; and *Center Neurology, P.C. v. James C. Lowe v. Wal-Mart Stores, Inc. Associates Health and Welfare Plan*, Case No. 97-VS-0124325-AA, respectively.

[2] Apparently, the case, *Columbia West Paces Ferry Medical Ctr. v. James C. Lowe v. Wal-Mart Stores Inc., d/b/a Wal-Mart Health Care*, Case No. 96-VS-0113449-JJ, was originally filed in the State Court of Fulton County and was transferred to the Superior Court of Fulton County and is presently before Judge Wendy Shoob. The Center Neurology case is pending in the State Court of Fulton County before Judge Jerry Baxter.

clear from the record that a motion for summary judgment is currently pending in the West Paces Ferry Medical Center case in the Superior Court of Fulton County wherein the Defendants have raised the identical issue as that before the undersigned; that Plaintiff is precluded from recovering from the Wal-Mart Health Plan as a result of his refusal to sign the subrogation and reimbursement agreement.

After discussing the issue with both parties in chambers, it is apparent to this court that the instant case should be stayed pending resolution of the cases in State and Superior courts of Fulton County. The Georgia courts have concurrent jurisdiction over the instant action. 29 U.S.C. § 1132(e)(1). Both sides agree that they are parties in the two cases pending in state court, that the same issue is key to all three cases, and that any determination made in the State or Superior court will be dispositive of the instant action.[3]

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[3] Defendants' reliance on *Unisys Medical Plan v. Timm*, 98 F.3d 971 (7th Cir. 1996), for the proposition that the instant action should not be stayed pending the resolution in the Georgia state courts, is misplaced. In *Unisys*, Gary Timm and his wife sued a number of tortfeasors in Wisconsin state court for injuries received. Timm's insurer, Unisys, paid his medical bills. The plan required Timm to reimburse Unisys if he received outside compensation for his injuries. The Timms settled the personal injury case. After the Timms settled, Unisys filed suit in federal court seeking reimbursement under ERISA. The Timms filed a motion to stay pending resolution of the state court litigation. The Seventh Circuit upheld the district court's denial of Defendant employee's motion to stay the federal proceedings pending resolution of the state proceedings because the state action would have had no preclusive effect on the federal action as the reimbursement issue was never litigated in state court. However, in the instant action, it is clear, and the parties agree that resolution of the state proceedings

(Continued on following page)

The United States Supreme Court in *Arizona v. San Carlos Apache Tribe of Arizona*, 463 U.S. 545 (1983) held that where a state court has jurisdiction, "concurrent federal proceedings are likely to be duplicative and wasteful" and can create "the serious potential for spawning an unseemly and destructive race to see which forum can resolve the same issue first. . . ." *Holmes Financial Associates, Inc. v. Resolution Trust Corporation*, 33 F.3d 561, 563 (6th Cir. 1994), quoting, *Arizona v. San Carlos Apache Tribe of Arizona*, 463 U.S. 545, 567 (1983). Therefore, the Supreme Court held "that although the district court was not required to defer to concurrent state proceedings, its decision to do so was not error." *Id.*

Accordingly, this case is hereby STAYED pending resolution of the pending cases in the State and Superior courts of Fulton County. The court will reconsider this decision upon information by the parties that the Georgia courts have ruled on whether the Plaintiff is precluded from recovering from the Wal-Mart Health Plan as a result of his refusal to sign the subrogation and reimbursement agreement. Defendants' motions: for summary judgment [#23]; to strike Plaintiff's motion for summary judgment as untimely [#30]; for leave to file a supplement to their motion for summary [#40]; for enlargement of time to file an answer to the amended complaint [#42-1]; and to set aside default judgment [#42-2] are hereby DISMISSED WITHOUT PREJUDICE with a right to refile upon resolution of the cases in the State and Superior Courts of Fulton County.

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will have preclusive effect over the present case. [Tr. Hearing at 3, 5, 7 & 27]

Plaintiff's motions: to alter or amend judgment [#27]; for summary judgment [#28]; to alter or amend the order of February 10, 1999 [#35]; for default judgment [#41]; and to dismiss the counterclaims [#43] are hereby DISMISSED WITHOUT PREJUDICE with a right to refile upon resolution of the cases in the State and Superior Courts of Fulton County.

The Clerk is directed to administratively close the file.

SO ORDERED, this 24 day of May, 1999.

/s/ Orinda D. Evans
ORINDA D. EVANS
UNITED STATES
DISTRICT JUDGE

CIVIL ARBITRATION PROGRAM
IN THE STATE COURT OF FULTON COUNTY

Center Neurology, P.C.	:	
	:	STATE COURT
	:	CASE NO.:
Plaintiff(s)	:	97VS0124325
vs.	:	JUDGE ALPHA CODE: A
James C. Lowe, Wal-Mart Stores, Inc.	:	
d/b/a Wal-Mart Stores, Inc.,	:	ARBITRATION FILE
Associates Health & Welfare Plan	:	NO.: 2002*050
Defendant(s)	:	

OATH OF ARBITRATORS

(Filed Jun. 5, 2002)

We do solemnly swear (or affirm) that we will support, obey and defend the Constitution of the United States and the Constitution and Laws of this State and that we will discharge the duties of our office with fidelity.

Les R. Winn		/s/ L. R. Winn	
Panel Chairman	(Print)		(Signature)
Fred McLam		/s/ F.C. McLam	
Panel Member	(Print)		(Signature)
Faye Levine		/s/ Faye Dora Levine	
Panel Member	(Print)		(Signature)

AWARD

WE THE UNDERSIGNED ARBITRATORS, HAVING BEEN DULY APPOINTED AND SWORN (OR AFFIRMED), MAKE THE FOLLOWING AWARDS:

We find for the Plaintiff against James C. Lowe, Wal-Mart Stores, Inc. d/b/a Wal-Mart Stores, Inc. Assoc. Health &

Welfare Plan, et al jointly and severally in the amount of $5,000.00 (Five thousand), Arbitrator, dissents.

Date of Hearing 6-5-02 /s/ L. R. Winn
Panel Chairman (Signature)

Date of Award 6-5-02 /s/ F.C. McLam
Panel Member (Signature)

Fred McLam, Dissents

Faye Dora Levine
Panel Member (Signature)

TIME CONSUMED FOR ARBITRATION HEARING 2 HOURS

NOTICE: The above award will become the Judgment of this Court unless, within 30 days of the filing of this Award, a demand for jury trial is filed with the Court.

JUDGMENT

NO DEMAND HAVING BEEN FILED FOR TRIAL WITH THE COURT AND THE THIRTY (30) DAY TIME PERIOD HAVING LAPSED;

IT IS HEREBY ORDERED AND ADJUDGED THAT THE ABOVE ARBITRATION AWARD BE MADE THE ORDER OF THIS COURT.

[LOGO] THIS 2ND DAY OF DECEMBER.

/s/ Penny Brown Reynolds
JUDGE
STATE COURT OF
FULTON COUNTY

I do certify that the within foregoing is a true complete and correct copy of the original in said case, as appears by the original on file in the office of Clerk of Fulton State Court, Consisting of one pages.
Witness my hand and the seal of said Court this the 11th day of December 2002

/s/ [Illegible]
DEPUTY CLERK,
FULTON STATE
COURT

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 03-12667-JJ

JAMES C. LOWE,

Plaintiff-Appellant,

versus

WAL-MART STORES, INC. ASSOCIATES HEALTH AND WELFARE PLAN, ET AL.,

Defendants-Appellees.

On Appeal from the United States District Court
for the Northern District of Georgia

ON PETITION(S) FOR REHEARING AND
PETITION(S) FOR REHEARING EN BANC
(Opinion___, 11th Cir., 19___, ___F.2d___).

(Filed Apr. 9, 2004)

Before: ANDERSON, MARCUS and WILSON, Circuit Judges.

PER CURIAM:

The Petition(s) for Rehearing are DENIED and no Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure), the Petition(s) for Rehearing En Banc are DENIED.

ENTERED FOR THE COURT:

/s/ Stanley Marcus
UNITED STATES CIRCUIT JUDGE

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

1. **THE CONSTITUTION OF THE UNITED STATES** Art.I Sec.9 (C1.3 and 10).
Provide in pertinent part:
(Cl.3) "No Bill of Attainder or Ex Post Facto Law shall be passed."
(Cl.10) "No State shall . . . pass any Bill of Attainder, Ex Post Facto Law, or Law Impairing the Obligation of Contracts . . . "

Art.III Sec.2 Par [2] Provides in pertinent part:
" . . . In all the other Cases before mentioned, the Supreme Court shall have appellant Jurisdiction, both as to law and fact . . . "

2. **The Fifth Amendment to the Constitution** provides in pertinent part: "nor shall any person . . . . be deprived of life, liberty, or property, without due process of law."

3. **The Tenth Amendment to the Constitution** provides: "the powers not delegated to the United States by the Constitution, nor prohibited by it to the States are reserved to the States respectively, or to the people.

4. **The Fourteenth Amendment, Sec.1 to the Constitution** provides in pertinent part: "No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States, nor shall any State deprive any person of life, liberty or property without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

5. **The Federal Arbitration Act (FAA)** 9 *U.S.C.A.* 1 *et seq*. "Provides for resolution of disputes and claims subject to mediation and arbitration."
ERISA actions are subject to The "FAA."

6. **The McCarran Ferguson Act** 15 *U.S.C.A.* 1011 *et seq*. Provides in pertinent part "That the ability to regulate Insurance . . . will be reserved to the several States.

7. **The Employee Retirement Income Security Act (ERISA)** 29 *U.S.C.A.* 1001 *et seq*. is a comprehensive Act that deals with pension plans and group health benefit plans. The stated purpose of the ERISA Act "is to ensure that each plan participant and beneficiary receive all of the benefits due to said individual."

8. **Labor Regulations Sec. 2560.503-1(b)(1)(iii)** provides in pertinent part that: "Does not contain any provision and is not administered in a way, which unduly inhibits processing of Plan Claims."

9. **Federal Rules of Appellant Procedure,** Rule 36 I.O.P. (2) and *F.R.A.P.* Rule 36 I.O.P. 11th Cir. Cir.R.36-2 establish the Rule of "Binding Precedent" and "Persuasive Precedent." Mandates issued by the Court are Binding or Persuasive respectively.

10. **Federal Rules of Civil Procedure,** Rules 12(a)(1)(A) and Rule 16(b), and Rule 16(e), and Rule 26(a)(1) as shown in 151 FRD 147 and Rule 37 establish congressionally mandated Rules to be observed within District Courts.

11. **CONSTITUTION OF GEORGIA**
    - Art.I Sec.I Par.I "No person shall be deprived of life, liberty or property except by due process of law"
    - Art.I Sec.I Par.X Provides in pertinent part that: "No bill of attainder, ex post facto

law, retroactive law, or laws impairing the obligation of contract or making irrevocable grant of special privileges or immunities shall be passed."

12. **GEORGIA ARBITRATION CODE *O.C.G.A.* 9-9-1 *et seq.*** provides for "Alternative Dispute Resolution" and mirrors the Fed. Arbitration Act, as further set-out in "No.5" above.

13. ***O.C.G.A.*** 1-3-5; 1-3-10; 9-11-17(a); 9-11-56(c); 9-12-16; 9-12-40; 10-7-4; 13-8-2; Are Georgia Codes of General Application, therefore would enjoy "*Preemption Exemption*" under the ERISA Act.

14. ***O.C.G.A.*** 9-11-17 is a Georgia State Statutory Code that allows absolute assignment of a given right under Georgia Law.
The Supreme Court of Georgia has interpreted this Statute within; *Allianz Life v. Riedl*, 444 S.E.2d 736 (Ga 1994), resulting in the decision that "*Assignment*" under Georgia Law is "*Absolute*" and said ruling by the highest Court in this State is binding on The 11th Cir. Court of Appeals. This Statute "*Regulates Insurance*" and therefore would enjoy "*Preemption Exemption*" under the ERISA Act.

15. ***O.C.G.A.*** 10-7-4 is a Georgia State Statutory Code that establishes the relationship of "*Suretyship*." This Code is used in insurance contracts and therefore would enjoy "*Preemption Exemption*," under The ERISA Act.

16. ***O.C.G.A.*** 33-24-56.1 is a Georgia State Statutory Code that establishes "*The MAKE WHOLE DOCTRINE*."

17. ***O.C.G.A.*** 44-12-24 is a Georgia State Statutory Code that forbids "*Assignment of the Right of Action*" against a third-party tort-feasor.
The Georgia Supreme Court has interpreted this Statute within: *Wrightsman v. Hard. Deal, Mut. Insurance Co.* 147 S.E.2d 860 (Ga 1966), resulting in the decision that "Assignment of the Right of Action against a Third-Party Tort-feasor is Forbidden" and said ruling by the highest Court in this State is binding on The 11th Cir. Court.